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ABSTRACT

This family life instructional unit is organized around four themes: (1) the importance of families; (2) human growth and development; (3) dilemmas and issues; and (4) promoting positive lifestyle practices. Lessons in the dilemmas and issues section include more in-depth information on subjects such as marriage and issues related to sexuality and reproduction such as sexual abstinence, teenage pregnancy, drugs and pregnancy, sexually transmitted diseases and sexual abuse prevention. (JD)

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family life education

grade 9

optional health unit interim guide

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family life education grade 9

optional health unit interim guide

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PREFACE

The Family Life Education optional unit of the Health Education curriculum consists of four components, the overview (a brief philosophical statement outlining rationale, goals, objectives and suggested implementation) and three grade level guides for Grades 5, 7 and 9.

The unit has been developed under the direction of a broadly-based curriculum committee composed of representatives of parents, health educators, health-care professionals, school administrators, and teachers. It is based on universally accepted values and reflects the contemporary needs and interests of Manitoban young people. This made-in-Manitoba Family Life Education optional unit represents the current emphasis in health education on preventive medicine, total well being and the assumption, where possible, of individual responsibility for health.

The content of the Grades 5 and 7 instructional packages is organized around five themes:

1. The Importance of Families
2. Human Growth and Development
3. Relationships and Responsibilities
4. Sexual Abuse Prevention
5. Promoting Positive Lifestyle Practices

At the Grade 9 level, the content is organized around four themes:

1. The Importance of Families
2. Human Growth and Development
3. Dilemmas and Issues
4. Promoting Positive Lifestyle Practices

Lessons in the Dilemmas and Issues section include more in-depth information on subjects such as marriage and issues related to sexuality and reproduction such as sexual abstinence, teenage pregnancy, drugs and pregnancy, sexually transmitted diseases and sexual abuse prevention.

At each grade level, the summary lesson at the end on well-being and lifestyle suggests positive ways to enhance health. The lesson provides students with an opportunity to recognize practices that compromise health, to plan ways to change such unhealthy behavior and to develop health patterns consistent with optimal well-being.

Grade level materials include approximately fifteen age-appropriate lessons that contain student objectives, suggested activities, teaching aids, teacher background notes, references and information about required materials. The teaching methodology is varied and is consistent with standard practice in schools. Family privacy is to be maintained in all instruction.

Each grade level unit is intended to be taught within the time frame of the Health Education curriculum--a six-to-eight week block. Instruction time for Health at grade 5 is 60 minutes, for grades 7 and 9, 75 minutes per five-day cycle.

IT IS IMPORTANT THAT THE FAMILY LIFE EDUCATION OPTIONAL UNIT BE TAUGHT BY CAREFULLY SELECTED AND TRAINED TEACHERS. AVAILABLE COMMUNITY RESOURCES MAY ALSO BE USED TO SUPPORT CLASSROOM INSTRUCTION.

THE OVERVIEW AND THREE GRADE GUIDES ARE INTERIM STATUS WHICH MEANS THAT THEY ARE PROPOSED FOR USE IN SCHOOLS AND ARE NOT CONSIDERED PROVINCIALLY MANDATED.

School divisions are encouraged to set up a Family Life Education review committee to study the materials and assess their suitability for use within the division. School divisions may make their own modifications according to the needs and interests of the children and parents they represent.

As has been the case in Manitoba for many years, parents who object to Family Life Education taught at the school retain the option of withdrawing their children from all or portions of the instruction.

ACKNOWLEDGEMENTS

Manitoba Education expresses its appreciation to the writers of the Family Life Education Unit: committee members Mary Brown and Joyce MacMartin who prepared the instructional materials and Dawn White who prepared the Rationale.

Manitoba Education would also like to acknowledge the contributions of the following members of the Health Education Curriculum Committee who critiqued this optional unit of instruction and express gratitude for their dedication to this program.

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GRADE 9 **1.0 Importance of Families** **Lesson 1.1**

TOPIC

Family Life Stages

STUDENT OBJECTIVES

The student will be able to:

1. describe family life stages,
2. predict events that may occur during family life stages and the effect they may have on family members.

SUGGESTED STUDENT ACTIVITIES

- Discuss the family life stages.
- Complete a worksheet on one family stage as a small group project.
- Report group work to the class.
- Participate in a discussion following each group report.

REQUIRED MATERIALS

- Teacher Background Notes: Family Life Stages
- Teaching Aid: Life Stages Worksheet

RESOURCES

1. Henderson, Gail. Dimensions of Life. Cincinnati, OH: South-Western Publishing, 1985.
2. Leavenworth, C., et al. Family Living. Englewood Cliffs, NJ: Prentice-Hall, 1985.

DESCRIPTION OF LESSON

I. INTRODUCTION

Introduce this lesson by explaining that the family develops and changes from stage to stage. At the same time, individual family members move through their own developmental changes. A family is a committed group of people who live together in a home and provide care, nurture and support for its members. Couples can expect to go through many stages throughout their married lives. These stages are fairly predictable and form a pattern known as the family life stages.

II. SUGGESTED STUDENT ACTIVITIES

A. Using a combination of lecture and discussion, introduce the life stages of families. These include:

DESCRIPTION OF LESSON

Stage I	Adults - usually newly married pair - no children . adjustments made to new marital status . a time to pursue a career, travel . opportunity to learn more about each other
Stage II	Adults - Child-Rearing Families . stage begins with the addition of a child . new attitudes develop about money, time, parenting responsibilities and friends
Stage III	Adults - Preschool Children - The Crowded Years . heavy demand on the time and energy of parents . financial commitments
Stage IV	Adults - School-Age Children . continued support by parents required . time and energy of parents may be taxed with children's activities (sports, clubs, music lessons)
Stage V	Adults - Teenagers . family feels the effects of crowding . expensive time, e.g., clothing, food, education . teenagers may spend little time with the parents . parents may have more time for each other
Stage VI	Adults - Launching Years . may be an enjoyable time for the family, e.g., graduation, post-secondary education, weddings . family may feel a sense of accomplishment
Stage VII	Adults - Empty Nest . children have left the home . financial support is reduced . greater opportunity for work, travel, leisure, companionship of partner . perhaps a time of grandparenthood
Stage VIII	Adults - Aging Family . retirement may occur . opportunity to pursue new interests . may have increased time for family members, including grandchildren . at this stage change of housing might be considered

There are variations in family life stages, e.g., couples who are childless may skip several stages. Death or divorce and remarriage will cause a readjustment to the model. The "sandwich family" is a recent societal trend. This family has experienced the empty nest stage. Their children have come back and, in some instances, bring children with them. At the same time, the sandwich family has pressures and responsibilities relating to aging parents. As a result they are feeling pressured or "sandwiched" from both sides.

B. Distribute the Family Life Stages Worksheet. Divide the class into small groups. Assign each group one of the family life stages. Suggest that each group select a reporter. Have each group discuss events that may happen during their assigned family life stage. Compile the events and the effect on the family.

C. Have reporters give a summary of their group work. To guide the discussion after each life stage report, use the suggested questions.

Questions for discussion:

- At each family stage, what do you feel would be the greatest pleasures, the greatest pressures, and the greatest problems?
- Explain how these family life stages overlap.

At the conclusion of the reports, discuss the following question.

- In your opinion, which stage would be the most hectic, the most carefree, the most satisfying?

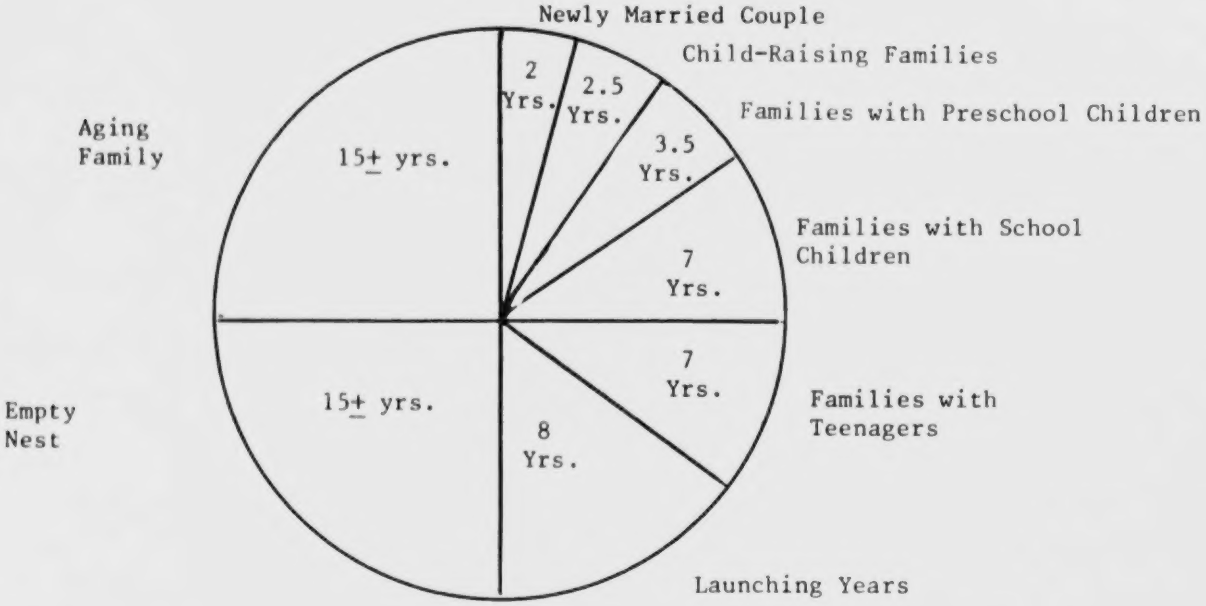
III. SUMMARY

Review the definition of the family. A family is a committed group of people who live together in a home and provide care, nurture and support for its members.

Reinforce the idea of a family as a dynamic unit of people. The traditional view of family life stages is a model within which there are innumerable variations. Emphasize that family stages are developmental and that, within each family, events are uniquely different.

TEACHER BACKGROUND NOTES: FAMILY LIFE STAGES

Couples can expect to go through many changes throughout their married lives. These changes are fairly predictable and form a pattern known as the family life stages. At each stage, the couple is presented with new challenges and demands as well as the joys and sorrows that accompany each change.



N.B. The years represented here are approximate.

1. Newly-Married Couple

   The first few years of a young couple's life are devoted to learning about one another, to establishing themselves financially, and adjusting to their new marital status. This stage usually lasts a few years.

2. Child-Raising Families

   With the arrival of the first child, couples move into the second phase of the family life stages. The addition of children to the family requires new attitudes towards money, time, space, and possibly the acquisition of new friends who share an interest in child development and parenting.

3. Families with Preschool Children

   This stage exerts great demands on the time and energy of mothers and fathers. In fact, parents may find themselves with little money or time for activities other than those involved in meeting the needs of their children. Both parents may need or choose to work to provide a desired level of living or one parent may remain at home full time to care for the young children

4. Families with School Children

Although school-aged children do not demand of their parents the intense physical care that preschool children do, parents may find their energies (and finances) stretched as they support their children in various sports, clubs, etc., involving friends or the school. For some families, there is little time, energy, or money to involve themselves in activities other than those which directly affect their family members.

At this stage, the parent who has remained at home may begin to work outside the home to help support the family financially.

5. Families with Teenagers

The family, at this stage, may feel the effects of crowding. Teenage children are expensive to clothe, feed, entertain, and educate. Although teenagers may prefer to spend little time with their parents, parents are nonetheless very involved and concerned for the well-being and future successes of their children.

As teenagers are relatively self-sufficient, parents may once again find they have more time to themselves and for each other.

6. Launching Years

During this stage, parents gradually send their children forth into the world to establish their own independence through education, work, marriage, and/or the forming of families of their own. Both parents and children may experience a feeling of pride and accomplishment.

7. Empty Nest

After all of the children have been launched, parents return to being a couple again. The financial needs of their children has been removed, and parents may find themselves enjoying work, travel, leisure and the companionship of their partner. The empty nest period allows couples time to prepare for retirement. A recent change in this state is the development of the sandwich family in which a couple's children come back to the empty nest, sometimes with their own children. Aging parents may require assistance at this point since the "sandwich" family feels pressure from both sides.

8. Aging Family

Individuals and couples who are prepared for retirement will not find the adjustment to leaving work difficult. It is possible for aging individuals to become involved in meaningful and stimulating activities. They may also provide support to their children.

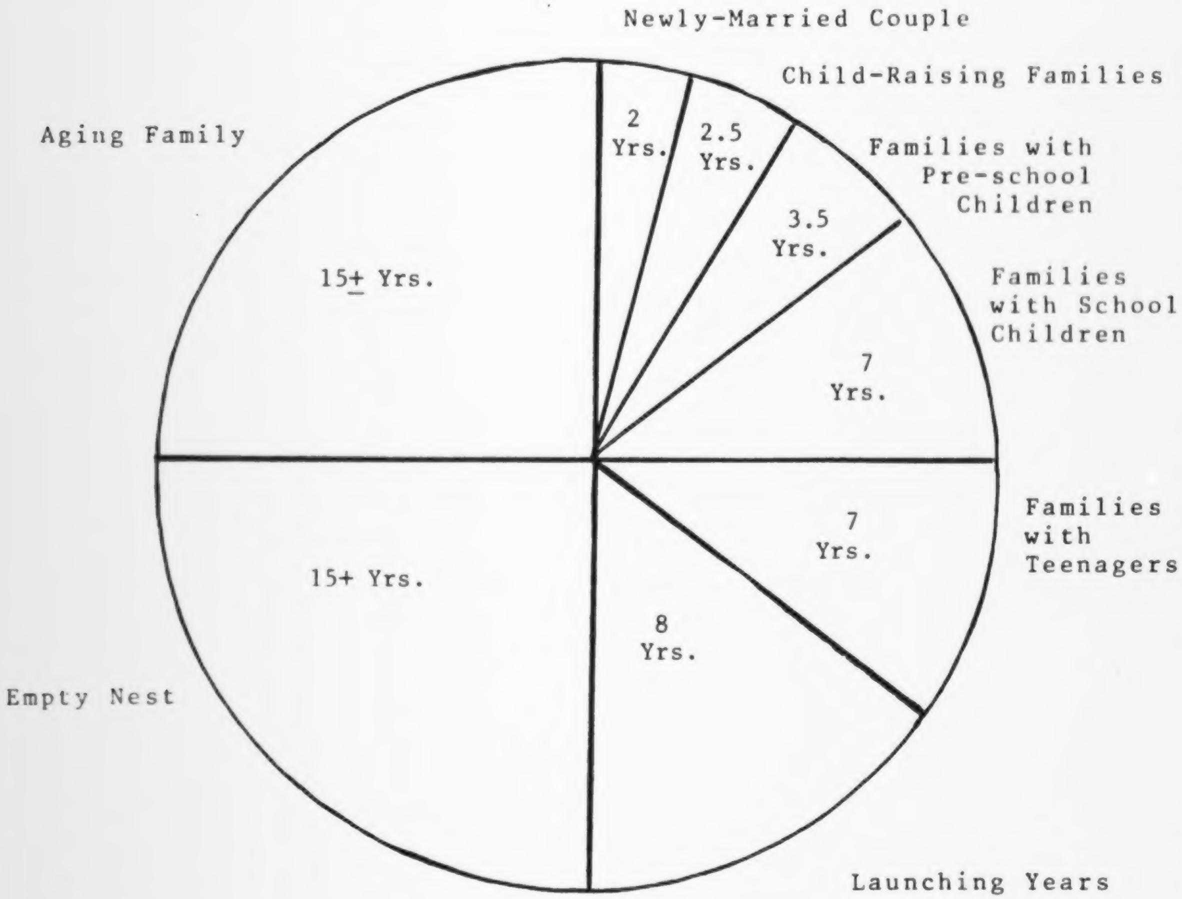
This eight point outline is a traditional look at the family life stages. It represents a model within which there are innumerable variations. For example, couples who are childless skip several of these stages. Illness, death, divorce, or remarriage can cause a readjustment of the model. Couples who have children after many years of marriage or space their children several years apart end up being in more than one stage at a time.

REFERENCES:

1. Henderson, Gail. Dimensions of Life. Cincinnati, OH: South-Western Publishing Co., 1985.

2. Leavenworth, Carol, et al. Family Living. Englewood Cliffs, NJ: Prentice-Hall, 1985.

LIFE STAGES WORKSHEET



Life Stage ________________

LIFE STAGE EVENTS	EFFECTS ON FAMILY

TOPIC

Family Life Stages: Marriage

STUDENT OBJECTIVES

The student will be able to:

1. recognize the stages leading to marriage, the first of the family life stages,
2. recognize the differences between infatuation and love.

SUGGESTED STUDENT ACTIVITIES

- Complete a worksheet on the characteristics of an ideal mate.
- Discuss the stages of courtship leading to marriage.
- View a filmstrip on marriage.

REQUIRED MATERIALS

- Teacher Background Notes: Marriage
- Teaching Aid: Ideal Mate Checklist
- Filmstrip: "And They Lived Happily Ever After" (Guidance Associates)

RESOURCES

1. Leavenworth, Carol, et al. Family Living. Englewood Cliffs, NJ: Prentice-Hall, 1985.
2. Ryder, Verdene. Contemporary Living. South Holland, IL: Goodheart Willcox Co., 1981.
3. Westlake, Helen Gum. Relationships: A Study in Human Behavior. Lexington, MA: Ginn and Co., 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

Introduce this lesson by explaining that the union of two people in a marriage usually follows a developmental process which begins with casual dating, progresses to serious dating and, finally, to love and the decision to make a permanent marriage commitment. Marriage is a commitment of two people to love, honour, and support each other for a lifetime. The married couple is the first stage of the family life stages identified in the previous lesson.

DESCRIPTION OF LESSON

II. SUGGESTED STUDENT ACTIVITIES

A. Ask students to consider ten qualities of an ideal mate. Distribute the worksheet, Ideal Mate Checklist. Have students list the 10 characteristics and rank them in order from 1 to 10 (1 being the most important). Characteristics to consider include some of the following:

- health
- pleasing personality
- mutual attraction
- similar education
- dependable character
- emotional stability
- similar religious background
- similar educational background
- intelligence
- ambition
- desire for home and children
- neatness
- financial prospects
- sense of humour

Have each student compare the list with another student. As a class, discuss the results of this exercise. Compare male and female lists for similarities and differences.

B. Discuss the stages of courtship leading to marriage. These include:

- casual dating
- serious dating
- engagement
- marriage

Explain how love moves through various stages from attraction to a particular person to a sense of mutual dependence on each other for support and fulfillment of emotional needs. Discuss romantic love, intellectual love and sexual love. For love to grow, romantic and intellectual love must be present.

Discuss the differences between infatuation and love. Using the chalkboard, list some characteristics of each.

Discuss the purpose of the engagement period:

- to announce to family, friends, and society the couple's intention to marry,
- to give time for the couple to evaluate their plans for the future,
- to plan for the wedding ceremony.

C. View the suggested filmstrip.

Questions for discussion:

1. What is the difference between love and infatuation?
2. What advice would you give someone contemplating marriage who wasn't sure that he/she was in love?
3. What do you think are the most important qualities people who are successful in marriage possess?
4. What are some major problems facing young people who are entering marriage?
5. Is marriage for everyone? Explain.
6. What might be the greatest pleasures or possible disappointments at this first stage of the family life stages?

III. SUMMARY

Marriage based on a deep, shared love can be the most positive kind of love. A couple becomes a "family." They have pledged to love and care for one another during their entire lifetime. Such a commitment requires careful consideration by both partners. Marriage is the beginning of a developmental life stage for families.

TEACHER BACKGROUND NOTES: MARRIAGE

Infatuation	Love
1. Infatuation is "love at first sight," when two people are strongly attracted to each other.	1. Love involves a deeper knowledge than just attraction.
2. Infatuation involves being "in love with love." Novelty is a big element--it is the kind of love that leaves you breathless.	2. Love involves a recognition and acceptance of the total personality of the other person.
3. Infatuation is self-centered; the other person becomes a means of self-satisfaction.	3. Love is other-person centered. It results in sharing.
4. An infatuated person may lose ambition and interest in everyday affairs, e.g., may daydream.	4. An individual in love works for their mutual benefit, e.g., he/she may plan and save for the future.
5. Infatuation involves idealization, accompanied by the disregard of reality.	5. Love is an outgrowth of appreciation for another.
6. Physical attraction plays a greater part when two people are infatuated.	6. Physical attraction is a part of the total relationship.
7. Infatuation may change suddenly and unpredictably.	7. When love changes, the reasons tend to be more or less apparent.
8. An infatuated couple tends to feel an urge toward immediate marriage.	8. Love tends to endure, to pass the test of time.

Love

Lasting, mature love may begin as a whirlwind or may develop as a gradual process. A whirlwind love is not a love to marry on until it has been tested by time and reason. No matter what pace it follows, love usually moves through the following stages:

1. An unexpected attraction to a particular person develops. As two individuals get to know each other better, a feeling of rapport develops.
2. As a couple become increasingly relaxed and comfortable with each other, they begin to talk and share goals.

3. As the couple develop more dependency on each other, each partner looks to the other for encouragement and support in everyday living as well as for the fulfillment of emotional needs.

A marriage based on a deep, shared love can be the most positive kind of love. When two people love each other with romantic love, intellectual love and physical or sexual love, they have the ingredients for a mature relationship.

1. Romantic love--love of the courtship, honeymoon, and anniversary, e.g., smile across the room, the thoughtful note.

2. Intellectual love--respect for the other person's intelligence, opinion, and integrity. It is the willingness to try to understand another's point of view. This love is probably the most important, for the respect for the intellect of the other person is the foundation of communication and conversation. Without a sharing of ideas, ideals, feelings, opinions, and humour, a couple cannot build companionship.

3. Sexual love--the joy of physical closeness, the warmth of the other person's embrace, perhaps the desire to be the shared parent of a child that may be created from this love. Love is often identified and confused with sex. Sexual love is certainly a part of marriage, but only a part. For love to grow the other parts, romantic love and intellectual love must be present.

The union of two people in marriage is a developmental process. It begins with casual dating, progresses to serious dating, and then, finally, to love and the decision to make a permanent marriage commitment.

I. FACTORS AFFECTING THE SELECTION OF A MATE

Studies indicate that many subconscious factors affect mate selection. These include:

1. Similarities: many people select mates similar to themselves. This means similar educational and occupational backgrounds as well as membership in the same religious, national or ethnic group. It may also mean being close to each other in age, geographic location, social class, and shared similar experiences, attitudes, interests and philosophies of living.

2. Differences: people select mates to work with them to gain personal social and financial goals who possess very different characteristics, perhaps possessing those the other lacks.

3. Chance: for most individuals, more than one person could be a potential candidate for marriage. Meeting the right person at the right time of life can affect who one marries.

4. Family: Although most parents in Canada do not actually choose who their children will marry, parental approval may affect mate selection and satisfaction.

5. Appearance: This may be of importance as one meets new acquaintances.

II. ENGAGEMENT

Engagement is an extension of the courtship period and the beginning of planning for married life. Its purpose is three-fold:

1. to announce to family, friends and society, a couple's intention to marry;

2. to plan for the wedding ceremony;

3. to provide the couple with a testing period during which the couple can discuss their values and make plans for the future. The following topics may be discussed or worked out during this period:

   - roles
   - further education
   - careers
   - habits
   - money management
   - vacations and leisure time
   - holidays to celebrate
   - children
   - religion
   - communication styles
   - in-laws
   - sexual intimacy and expectations
   - living arrangements
   - friendships
   - goals

III. MARITAL ADJUSTMENT

When two individuals choose to live together in a marriage relationship, successful adjustment is dependent upon their degree of commitment to each other and to the marriage. It is this determination or commitment for success that makes a marriage work.

Couples who are committed to their marriage share common characteristics. Happy couples, although sharing common goals, allow each other room to grow as individuals. They respect, trust and appreciate one another.

Satisfied couples listen to one another and try to resolve conflict in a non-destructive way. They discuss and make decisions together. They are good friends who are comfortable with each other and who communicate in a positive way.

Successful adjustment to marriage does not happen easily or readily. It requires time, tolerance and acceptance for the unique set of beliefs and attitudes each person brings into the marriage. Studies indicate that the more time couples spend talking to one another, the more likely they will achieve marital satisfaction.

RESOURCES:

1. Ryder, Verdene. Contemporary Living. South Holland, IL: Goodheart Willcox Co., 1981.

2. Leavenworth Carol, et al. Family Living. Englewood Cliffs, NJ: Prentice-Hall, 1985.

3. Westlake, Helen Gum. Relationships, A Study in Human Behavior. Lexington, MA: Ginn and Co., 1984.

IDEAL MATE CHECKLIST

RANK

1. ______________________________ ____
2. ______________________________ ____
3. ______________________________ ____
4. ______________________________ ____
5. ______________________________ ____
6. ______________________________ ____
7. ______________________________ ____
8. ______________________________ ____
9. ______________________________ ____
10. ______________________________ ____

GRADE 9 **1.0 Importance of Families** **Lesson 1.3**

TOPIC

Family Life Cycle: The Aging Stage

STUDENT OBJECTIVES

The student will be able to:

1. describe aging as a family life stage.

SUGGESTED STUDENT ACTIVITIES

. Complete Facts of Aging Worksheet.
. Complete a mini-biography on an older person.
. View a film and discuss a series of questions on life stages.

REQUIRED MATERIALS

. Teacher Background Notes: Aging
. Teaching Aid: Facts on Aging Worksheet
. Film: "Peege"

RESOURCES

1. Ambron, Susanne Robinson, and David Brodzinsky. Life-span: Human Development. New York: Holt, Rinehart and Winston, 1982.
2. Palmore, Erdman. "Facts on Aging: A Short Quiz." The Gerontologist, 14, No. 4 (1977), 315-20.
3. Schmidt, Verdyne. "Unit B: Later States in Family Life Cycle." Vista, 14, No. 2 (1982), 14.

DESCRIPTION OF LESSON

I. INTRODUCTION

Introduce this lesson by reviewing the concept of life stages from the previous lesson. This lesson will focus on the aging stage. Aging can be a productive life stage for many. Look, for example, at Jeanne Sauvé, Ronald Reagan, Pierre Trudeau, Pierre Burton, Pope John Paul, and Mother Teresa. They are all high profile leaders who also happen to be senior citizens. Few people would view them as being handicapped by age.

II. SUGGESTED STUDENT ACTIVITIES

A. Distribute the Facts on Aging Questionnaire. Ask students to quickly mark true or false beside the questions. Discuss the answers. Many students may not know that only a small percentage (5%) of seniors live in nursing homes, for example.

B. Heritage Assignment

It is difficult for us to appreciate our elders without knowing something about their life events, joys and sorrows. Have each student do a mini-biography on an elderly person of their choice, either a public figure, acquaintance, or family elder. They may wish to use autobiographies, photographs, legal documents, magazines, family stories or personal memories. The evaluation of this assignment might include use of resources and students' observations, which show, for example, a greater understanding and appreciation of the elderly person.

C. Prepare the students for the emotional nature of "Peege." Tell students that the film will deal with flashbacks to the various events in the life stages. Ask students to watch for particular life stages as they view the film and to observe the feelings of all the family members as they visit Peege.

Questions for discussion:

1. What did Greg think about on his way to see his grandmother? What life stages were represented in the flashbacks?
2. How were Greg's memories of his grandmother different from those of other family members who were talking as they drove to the nursing home?
3. Identify the life stage of the family. At what life stage is Peege?
4. Identify Greg's recollections.
5. What can we learn from this film to improve our relationships with elderly people?

III. SUMMARY

Reinforce the idea that the aging stage can be a productive time for many. Positive health, outside interests and satisfying family relationships are factors that influence how well an elderly person adjusts to this stage.

TEACHING BACKGROUND NOTES: AGING

Family Life and Aging

Many of the adjustments of aging lie within the context of family and work: retirement, the reduction of income, the death of a spouse. People benefit in old age from being married. They live longer and experience less mental illness and loneliness when there is a spouse to buffer them from the stresses of old age.

Most older people are neither abandoned nor isolated. They live independently of their children and, often, nearby. Elderly people rely on their children in times of illness but give as well as receive. Relationships with grandchildren may not seem as close as the grandchildren become older. Bereavement of a spouse represents the single greatest loss suffered by aging individuals. Of women over seventy-five years of age, 70 percent are widowed. Most prefer to maintain their independence in spite of loneliness. They often experience decreased income and social status. Good friends help.

Only about five percent of older people live in nursing homes. Usually the institutionalization of an older person is a last resort. Generally people enter an institution when their physical condition is increasingly deteriorating, and there is no other care available. Some people have difficulty adjusting to living in an institution; others find it offers a solution to loneliness. The family may have difficulty adjusting to the arrangement as well.

REFERENCE:

Ambron, Susanne Robinson, and David Brodzinsky. Lifespan: Human Development. New York: Holt, Rinehart and Winston. Chapters 18 and 19.

FACTS ON AGING WORKSHEET

1. All five senses tend to decline as one ages (some decline more than others).
2. The majority of elderly people are senile.
3. Physical strength tends to decline as one ages.
4. Most elderly workers cannot work as effectively as younger workers.
5. Most elderly people are set in their ways and unable to change.
6. Most elderly people usually take longer to learn something new.
7. It is almost impossible for most elderly people to learn new things.
8. In general, most elderly people are pretty much alike.
9. Most elderly people live in nursing homes.
10. Elderly people tend to become more religious as they age.

ANSWERS

1. T
2. F
3. T
4. F
5. F
6. T
7. F
8. F
9. F
10. T

REFERENCE:

Palmore, Erdman. "Facts on Aging: A Short Quiz." The Gerontologist, 17, No. 4 (1977), 315-16.

GRADE 9 **2.0 Human Growth and Development** **Lesson 2.1**

TOPIC

Puberty and Adolescence

STUDENT OBJECTIVES

The student will be able to:

1. recognize that hormones effect changes in males and females at puberty and during adolescence,
2. describe physical and social-emotional changes at puberty and during adolescence.

SUGGESTED STUDENT ACTIVITIES

- Participate in an illustrated lecture-discussion on the endocrine glands and their influence at puberty.
- See a film on the influence of hormones on growth and development.

REQUIRED MATERIALS

- Teacher Background Notes: The Endocrine System; Puberty and Adolescence: Growth and Development Changes; Primary, Secondary, and Social-Emotional Changes at Puberty and Adolescence
- Overhead Transparency: The Endocrine Glands
- Film: "Then One Year"
- Filmstrip Kit: "Coping with Adolescence: Understanding Puberty" (Learning Tree)

RESOURCES

1. Public health nurse or doctor
2. Manitoba Department of Education. "Module: Human Sexuality." *Teacher Background Material for the K-9 Health Education Program*. Winnipeg: The Department, 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

Puberty can be defined as the onset of adolescence, a life stage marked by changes in growth and development, particularly of a person's sexuality. Adolescence is a longer period during which time a young person acquires maturity--physical, social, emotional, and intellectual. At the end of adolescence a person is considered an adult. Girls begin puberty at about ten to twelve years of age whereas boys enter puberty one to two years later than girls. In some boys and girls, puberty may be delayed.

DESCRIPTION OF LESSON

The growth spurt and accompanying changes are gradual, being under the control and regulation of the endocrine system, notably under the influence of the pituitary gland. Its secretions are carried by the blood to target organs/glands such as the testicles (testes) and ovaries. These influences bring about sperm development and sperm emissions in boys and the onset of menstruation and ova development in girls. Related primary and secondary and social-emotional changes follow.

II. SUGGESTED STUDENT ACTIVITIES

A. Review the role of the pituitary gland and its effect at puberty on the testicles (testes) and ovaries. Review briefly the major endocrine glands. Have students suggest definitions of puberty and adolescence. Using a lecture and discussion or audio-visual presentation, discuss common changes that occur at puberty and adolescence.

Discuss examples of general changes in boys and girls at puberty. Some examples are:

- rapid growth spurt (increased height and mass)
- increased appetite
- decreased muscle coordination (awkwardness)
- skin changes - coarseness, oiliness
- increased perspiration (armpits, feet, and genital areas)
- periods of tiredness due to rapid growth
- voice changes - deepens as vocal cords thicken
- development of body hair

Encourage the class to suggest examples and list them on the blackboard under these headings:

- primary growth changes - those directly related to male and female reproduction and genitals

- secondary growth changes - those general growth changes in males and females

- social-emotional changes - those growth changes related to self-concept and interpersonal relationships

See Teacher Background Notes.

B. View the film, "Then One Year," or use filmstrips. Review key points.

DESCRIPTION OF LESSON

III. SUMMARY

Adolescence is a life stage between childhood and adulthood marked at its onset by rapid physical growth. It is accompanied by gradual sexual maturation, physical, social, and emotional changes. Although individual boys and girls develop at their own rates, characteristic patterns are evident. Students need assurance that they are progressing normally and guidance to help them develop positive attitudes that promote healthy growth and development.

TEACHER BACKGROUND NOTES: THE ENDOCRINE SYSTEM

A gland can be defined as a tissue or an organ that produces a chemical substance. Endocrine glands secrete hormones into the bloodstream and influence many body processes. The effect of hormone secretion can be both general and specific. For example, the thyroid gland produces thyroxin which affects general body metabolism. The pituitary gland produces oxytocin which stimulates contraction of the uterine muscles. Endocrine glands include the thyroid, the parathyroids, the adrenals, part of the pancreas, the pituitary and the sex glands. These glands work together to maintain metabolism and harmony between body organs.

The pituitary gland is located below the brain near the center of the head. It is considered the master endocrine gland because its secretions influence the activity of many other glands. These secretions include a growth-stimulating hormone, sexual-development hormones, a kidney-regulating hormone as well as hormones influencing both the thyroid and adrenal glands.

The adrenal glands consist of two parts: a medulla and a cortex. They are located on the upper part of each kidney. The medulla secretes the hormone epinephrine or adrenalin. Release of this hormone occurs when an individual is angry or frightened; it causes an increase in heart rate, blood pressure, blood sugar levels and blood flow to the muscles. Adrenalin or epinephrine has been called the emergency hormone as it prepares the body for action. The adrenal cortex secretes hormones which control sugar and protein metabolism and regulate salt and fluid balance.

The pancreas contains a group of cells called the "Islands of Langerhans" which produce insulin, a hormone vital to the metabolism of sugar. An insulin deficiency causes the disease, diabetes, which sometimes requires injections of the hormone, insulin, to control it.

The thyroid gland is located in front of the larnyx and produces the hormone, thyroxin. Thyroxin regulates the metabolism of the body: heart rate, respiration and the rate at which food is burned up. The thyroid gland requires adequate amounts of iodine for efficient functioning. Overactivity of the thyroid gland is called hyperthyroidism. This condition results in increased heart rate, blood pressure and nervousness and is characterized by bulging eyes and weight loss, in spite of a good appetite.

The parathyroid glands are located behind the thyroid gland. Their function is to secrete hormones to maintain the balance of calcium and phosphorous in the blood.

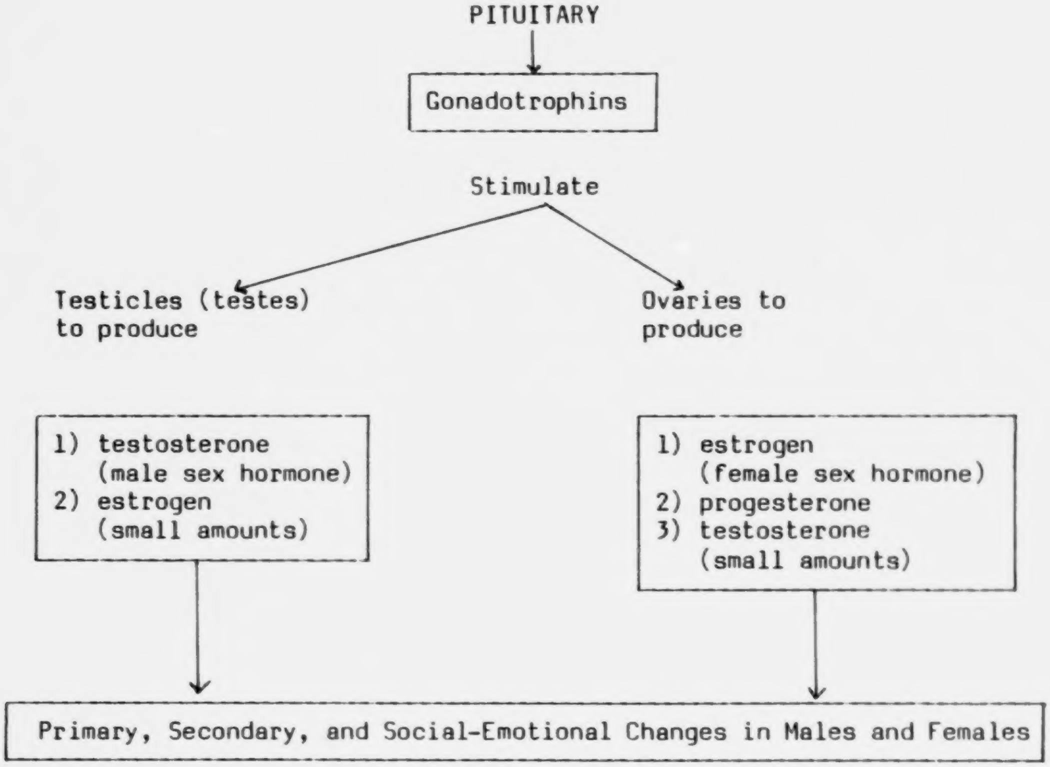
The *gonads* or *sex glands* are the ovaries in females and the testicles (testes) in males. The secretions of these glands help to differentiate male and female characteristics. From birth to puberty, these secretions are regulated by pituitary hormones. Hormones secreted by these glands during puberty cause the development of physical sexual characteristics. The ovaries in the female produce estrogen and progesterone which regulate the menstrual cycle and production of the ova or egg. The testicles (testes) secrete testosterone which regulates the development of male sexual characteristics and sperm cell production.

REFERENCE:

Manitoba Department of Education. "Module: Human Sexuality." *Teacher Background Material for the K-9 Health Education Program*. Winnipeg: The Department, 1984.

TEACHER BACKGROUND NOTES: PUBERTY AND ADOLESCENCE: GROWTH AND DEVELOPMENT CHANGES

The development of a person's primary and secondary sexual characteristics begins at puberty when the pituitary gland releases hormones called gonadotrophins. Although the onset of puberty is individual, students may need support if they are "late bloomers," feel awkward or feel unattractive to others.


PITUITARY
Gonadotrophins
Stimulate
Testicles (testes) to produce
Ovaries to produce
1) testosterone (male sex hormone)
2) estrogen (small amounts)
1) estrogen (female sex hormone)
2) progesterone
3) testosterone (small amounts)
Primary, Secondary, and Social-Emotional Changes in Males and Females

TEACHER BACKGROUND NOTES: PRIMARY, SECONDARY, AND SOCIAL-EMOTIONAL CHANGES AT PUBERTY AND ADOLESCENCE

	Male	Female
1. Primary Characteristics	- genitals grow and mature . penis, scrotum and testicles (testes) enlarge - sex hormones are produced - erections may occur spontaneously - ejaculation may occur	- genitals grow and mature . vulva, vagina and uterus enlarge - menstruation begins - ovaries produce sex hormones - ova develops in ovaries - ovulation begins - cervix produces mucus
2. Secondary Characteristics	- body matures . shoulders broaden . muscles increase in size and strength . hair develops on upper lip, face, legs, and pubis . voice deepens	- body matures . pelvic bony-girdle widens . hips develop fatty pads . breasts increase in size . pubic hair and axillary hair appears

3. Social-Emotional Changes

Male and Female

- uneasiness; preoccupation with physical change
- need to understand physical changes
- increased modesty and need of privacy
- need for reassurance that their sexual development is normal
- emotional reaction to any slight physical imperfection
- subject to states of anxiety
- burst of energy one day and no energy on the next

Male and Female

- emergence of sexual feelings
- change in attitudes towards the opposite sex
- sensitivity to physical contacts, e.g., showing affection
- search for self-identity and understanding
- need for more independence from the family; influence of peer groups increases in importance
- need to belong to peer groups
- strong need for acceptance by peers regarding dress, language, behavior, emotions, appearance
- assessment of family values and ideals
- increased decision-making about drugs, sexual activities and personal values

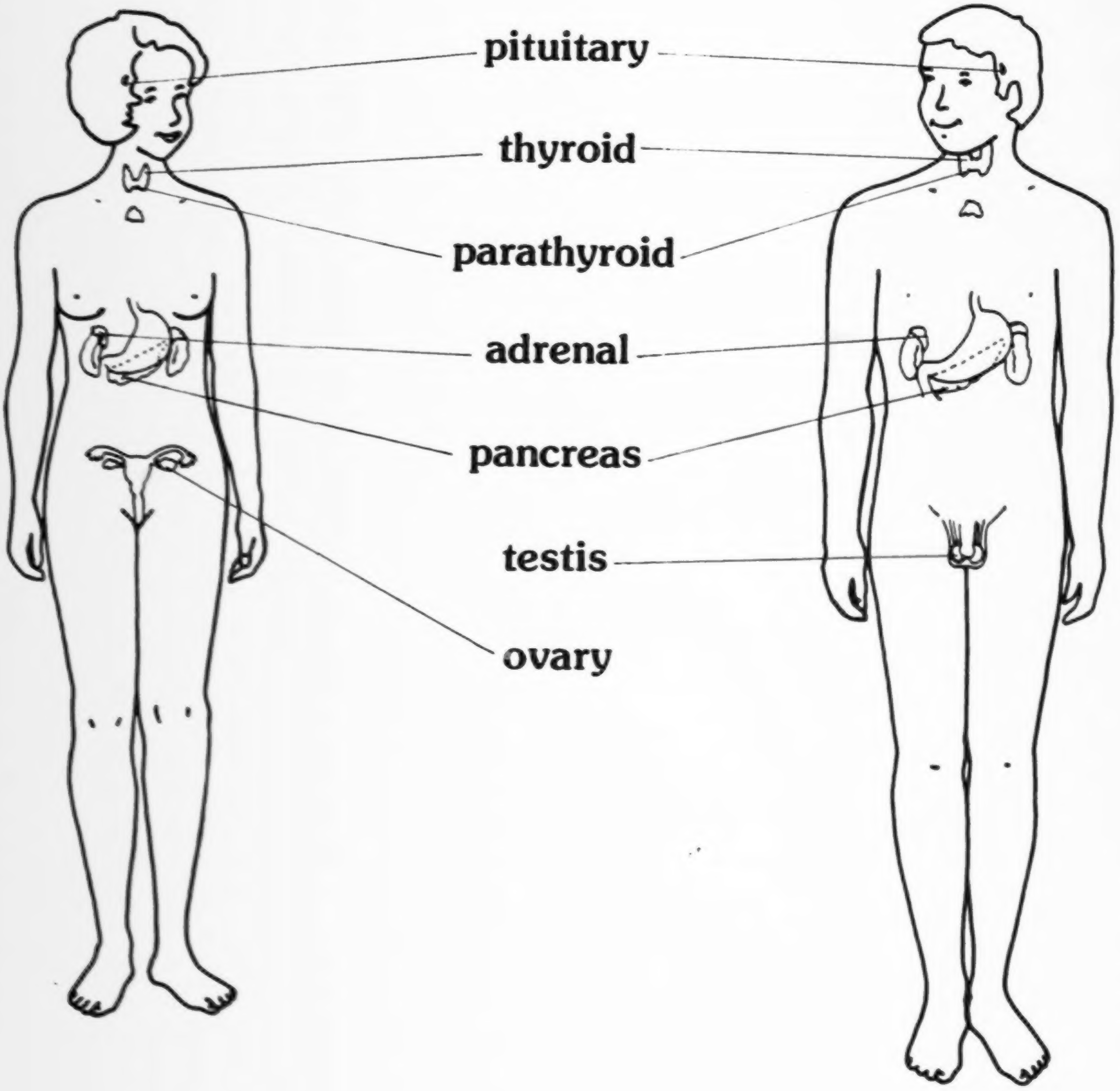
Transition to Early Adolescence (ages 10-13)

Physical Characteristics: Physical changes are most significant: young teens show increase in height, weight, strength, exercise tolerance and vitality in correspondence with enormous appetites and food consumption. Awkwardness and tiredness may accompany rapid physical growth. Both boys and girls are very aware of body appearance.

Psycho-Social Characteristics: Young teens show the need for security and love. Strong emotional ties and infatuations may develop. Peer popularity, conformity and acceptance are evident and/or often desired. Mixed groups are popular social groupings prior to heterosexual dating. There is need for personal recognition and acceptance. Fear of rejection by peers may be evident. The expression of emotions such as grief, shyness, jealousy, anger, guilt may intensify. New responsibilities and experiences may generate anxiety.

Intellectual Characteristics: Young teens show increase in communication and decision-making skills and increased tendency for introspection. They more rapidly see others' points of view and show increased interest in morals and values. There is a shift from concrete operational to abstract thinking. Thought becomes more future oriented and comprehensive.

THE ENDOCRINE GLANDS


pituitary
thyroid
parathyroid
adrenal
pancreas
testis
ovary

TOPIC

Male and Female Reproductive Systems

STUDENT OBJECTIVES

The student will be able to:

1. review the structure and function of the male and female reproductive systems,
2. explain the significance of the reproductive systems.

SUGGESTED STUDENT ACTIVITIES

- Participate in an illustrated lecture and discussion on the male and female reproductive systems.
- See a film(s) on male and female reproductive systems.
- Write a paragraph about the significance of the reproductive systems and sexual maturation.

REQUIRED MATERIALS

- Teacher Background Notes: Male Reproductive Organs; Female Reproductive Organs
- Transparencies: Male Reproductive System; Female Reproductive System
- Films: "Then One Year"
  OR "The Facts for Boys"
  "The Facts for Girls"

RESOURCES

1. Meeks, L.B., and P. Heit. Family Living and Human Reproduction. Toronto: Merrill, 1982.

DESCRIPTION OF LESSON

I. INTRODUCTION

At puberty, as a result of the influence and control of the endocrine system, boys and girls undergo many growth and maturation changes. In addition to height and weight increases, primary and secondary sexual characteristics gradually evolve.

Teenagers today need to understand the function of the male and female reproductive systems, to make important decisions about their own sexuality, and to be aware of possible risks to the health of their body systems.

Teenagers develop and mature at their own rates. Once their reproductive systems are mature, however, they are physically capable of producing new life. This does not imply that they are emotionally or intellectually capable of dealing with this process.

DESCRIPTION OF LESSON

II. SUGGESTED STUDENT ACTIVITIES

A. Review the key points from the film regarding the structure and function of both reproductive systems.

B. Using overhead transparencies, review the function of each organ of the male reproductive system. Terms: scrotum, testicles (testes), vas deferens, seminal vesticles, prostate gland, ejaculatory duct, penis, uretha.

Using overhead transparencies, review the function of each organ of the female reproductive system. Terms: vulva (including labia and clitoris), vagina, cervix, uterus, fallopian tubes, ovaries. The urinary opening and anus should be located; these are structures of the excretory and/or digestive systems.

C. Briefly review similarities and differences of male and female reproductive systems, and discuss the implications of sexual maturation.

Similarities

1. Both reproductive systems produce sex cells (sperm in the male system and ova in the female), each with half the genetic material to direct the genetic inheritance of offspring.
2. The gonads, or pairs of ovaries and testes that produce the sex cells, are about the same size and shape.
3. The pairs of organs release sex cells into pairs of tubes joined to a single structure.

Differences

1. The male reproductive organs are located in a structure outside the abdominal cavity, the scrotum; the female reproductive organs are located in the pelvic region of the abdomen.
2. Female organs are used to support, nourish and protect a developing baby. The male's organs are used to produce and place sperm cells inside the female.

D. Encourage students to write a paragraph that describes the significance of the reproductive systems and sexual maturation.

DESCRIPTION OF LESSON

III. SUMMARY

The production of reproductive cells and the act of procreation are essential for the continuation of the species. While sperm development occurs at puberty and continues throughout life, ova growth and development decline anywhere between the ages of 45 and 50. Menopause indicates that a woman no longer can bear children because her ovaries no longer produce ova.

Adolescence, the life stage between puberty and adulthood when males and females are reproductively mature and capable of reproducing life, is a critical stage of development. Being sexually mature does not mean being capable of rearing a family. Many traditions, values and responsibilities must guide and accompany maturation.

TEACHER BACKGROUND NOTES: MALE REPRODUCTIVE ORGANS

ORGANS	FUNCTIONS
Cowper's glands	. located below the prostrate, these glands secrete a small amount of alkaline fluid into the urethra just before the sperm reach this point
ejaculatory ducts	. a union of the vas deferens with a duct from each seminal vesicle
epididymus	. the place where mature sperm cells are stored prior to entering the deferens
penis	. the external genital organ through which the urethra passes; conducts semen to the vaginal canal
prostate gland	. a structure below the bladder surrounding the urethra and ejaculatory ducts that secretes an alkaline material to aid in sperm motility; this muscle contracts to expel the semen (ejaculation); tumors of the prostate occur fairly frequently in elderly men; examination of the prostate rectally is important for early diagnosis of cancer of the prostate
seminal vesicles	. two structures behind the bladder that produce alkaline secretions containing fructose; the material joins the sperm in the vas deferens to provide nourishment for the sperm and enhance its motility
seminiferous tubules	. the place where male sex cells are produced within each testis (testicle); the tiny coiled tubules have an approximate length of ½ mile (0.8 km)
scrotum	. a sac that supports and holds the testicles (testis)
testicles (testes)	. two glands within the scrotum that produce testosterone; testosterone influences sexual maturation and growth of reproductive cells called sperm; testicular examination is important for early detection of cancer of the testicle.
urethra	. a tube within the penis which is part of both the excretory and reproductive systems; it carries: - urine from the bladder to the outside of the body; and - sperm and semen from the ejaculatory duct through the urethra to the outside of the body
vas deferens	. one tube leading from each testicle (testis) to the urethra that transports sperm

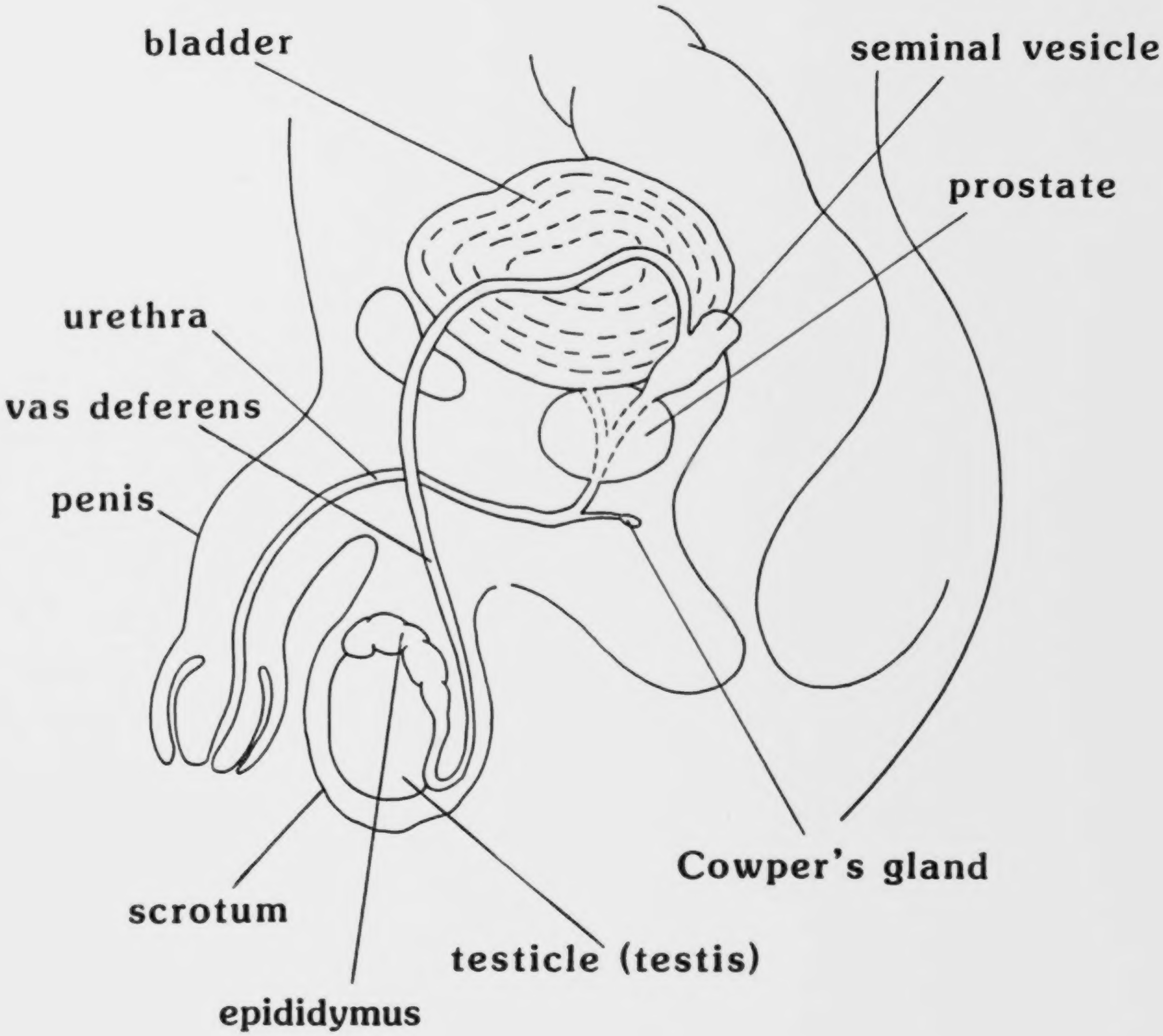
TEACHER BACKGROUND NOTES: FEMALE REPRODUCTIVE ORGANS

ORGANS	FUNCTIONS
cervix	. the entrance to the uterus found at the upper end of the vagina; the Papanicolaou test of cervical cells is important in cancer prevention and early diagnosis of cancer of the uterus
clitoris	. a small structure that corresponds to the penis; composed of erectile tissue which is highly sensitive
fallopian tubes	. two tubes adjacent to the ovaries which are attached to the upper end of the uterus and have a funnel-shaped opening; the ovum is swept into the tube at ovulation and is moved toward the uterus by cilia (hairs); fertilization of the ovum by a sperm occurs in the fallopian tube
labia	. two soft folds of tissue within the vulva which enclose two smaller folds that partially cover the clitoris, the urethral and vaginal openings
ovaries	. organs, connected by ligaments to the uterus (one on each side), which develop and store ova regularly; female sex hormones, regulated by the pituitary gland, cause ova to be released periodically during the menstrual cycle
uterus	. a muscular, pear-shaped organ in which the fertilized ovum grows and develops into a fetus; the uterine lining is shed regularly during menstruation if the ovum is not fertilized
vagina	. the opening through which menstrual discharge flows; a muscular organ designed to receive the male organ during sexual intercourse; the passageway through which a baby is born
vulva	. the area situated between the legs which protects the openings of the vagina and the urethra; it does not include the anus; on either side of the vulva are soft folds of tissue called labia

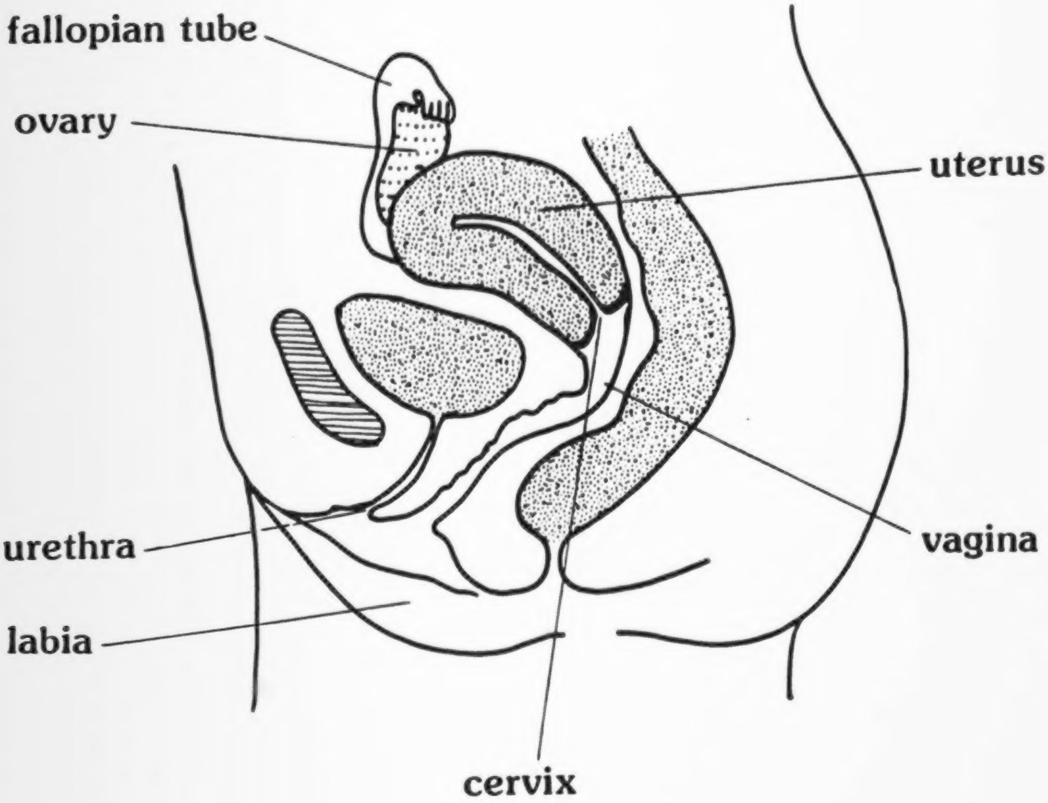
REFERENCE:

Meeks, L.B., and P. Heit. Family Living and Human Reproduction. Toronto: Merrill, 1982.

MALE REPRODUCTIVE SYSTEM


bladder
seminal vesicle
prostate
urethra
vas deferens
penis
scrotum
epididymus
testicle (testis)
Cowper's gland

FEMALE REPRODUCTIVE SYSTEM


fallopian tube
ovary
uterus
urethra
vagina
labia
cervix

GRADE 9 | **2.0 Human Growth and Development** | **Lesson 2.3**

TOPIC

The Menstrual Cycle

STUDENT OBJECTIVES

The student will be able to:

1. describe the hormonal regulation of the menstrual cycle;
2. identify positive health practices related to menstrual products and vaginal hygiene;
3. explain the importance of using appropriate practices that promote vaginal health;
4. propose health goals that promote the positive health of adolescents.

SUGGESTED STUDENT OBJECTIVES

- Explain the role of the hormones and events of the menstrual cycle.
- Complete a worksheet about events and regulation of the menstrual cycle.
- Substantiate health practices and choices of menstrual products.
- Formulate a set of recommendations to promote health and vaginal hygiene.
- State several health behaviors that indicate ways to promote individual health.

REQUIRED MATERIALS

- Teaching Aid: Student Study Questions: The Menstrual Cycle - Control and Regulation
- Transparencies: The Menstrual Cycle; The Menstrual Cycle Stages; Ovum Development and Release
- Teacher Background Notes: The Menstrual Cycle: Control and Regulation; Toxic-Shock Syndrome

RESOURCES

1. Public health nurse, doctor, health educator
2. From Fact to Fiction: A Teaching Guide on Menstruation and Menstrual Health. Lake Success, NY: Educational Dept. Tampax Inc., n.d.

DESCRIPTION OF LESSON

I. INTRODUCTION

This lesson may take two class periods.

DESCRIPTION OF LESSON

The regulation and control of growth and maturation is affected by hormones, glandular secretions of the endocrine system.

In females, a regular four-week cycle of hormonal changes which begins at puberty results in the menstrual cycle. The cycle is characterized by a building up and a sloughing of the uterine lining. The female cycle prepares the uterus to receive an ovum and maintain a pregnancy. Ovulation begins normally two weeks before each menstrual period. The significance of ovulation is that the female becomes reproductively mature and capable of producing a new life.

Many responsibilities accompany sexual maturation including learning new personal health and hygiene practices, taking sufficient exercise and rest, consuming nourishing foods, selecting and using safe menstrual products.

II. SUGGESTED STUDENT ACTIVITIES

A. Begin the discussion with questions about menstruation such as:

1. What are common terms for menstruation?
2. What main events occur during a menstrual cycle? (ovulation; uterine wall build-up and sloughing off)
3. How long is average length of cycle? (23-25 days may be the length of the cycle; it is often irregular at first.)
4. For how many days does the menstrual flow occur? (Once the cycle is established, the menstrual flow becomes regular and continues for 3-7 days.)
5. When does menstruation begin? (10-14 years; average age is 12)

Use an illustrated lecture approach to describe the events and controls of the menstrual cycle. An alternative approach is to use the Teacher Background Notes as student study sheets.

1. Events
    - a) ovum development
    - b) ovum release (ovulation) - stress the implications and significance of ovulation
    - c) uterine wall thickening
    - d) menstrual flow

2. Controls

   Discuss the hormonal control of the events of the menstrual cycle.

B. Prepare and distribute copies of the student questions A & B. Have students complete statements. Review answers with the class.

NOTE: This is the suggested ending to Part 1 of this lesson.

C. Menstrual Products

Make a list of menstrual product choices (e.g., napkins, tampons, pantyliners). Discuss the pros and cons for each. Substantiate the choice of these products by weighing the benefits vs. the risks.

Some examples that may be suggested follow:

Menstrual Products	Benefits of Use	Barriers/Risks/ Problems
(belt-free) napkins	. easy to use . some pre-wrapped . various absorbencies . no pantyliners needed . product sterilized . little/no menstrual odor when changed regularly . risk of TSS is almost eliminated	. some discomfort or inconvenience . may be bulky to wear and store . not all products pre-wrapped individually . require wrapping for use away from home . require wrapping for disposal; cannot be flushed . deodorant types may cause allergies
tampons	. convenient to carry and store . various absorbencies . product sterilized and individually pre-wrapped . flushable for easy disposal . convenient to use . little/no menstrual odor	. risk of contaminating product if user's hands not clean . (super) high absorbency products too bulky for easy removal from vagina for some women; difficult removal may cause tissue damage; infection becomes a risk

Menstrual Products	Benefits of Use	Barriers/Risks/ Problems
tampons	. risk of TSS quite low when used appropriately . may be useful for heavy flow days . convenient to use when participating in sports	. may be left inside vagina too long and/ or forgotten for days; risk of infection . some pre-wrapped products provide no applicators; infection may occur . applicators may be too hard and cause tissue abrasions; infection may occur . deodorant types may cause allergies
pantyliners	. convenient . avoids stains to underclothes when used with tampons . non-bulky . keeps underclothes dry from normal vaginal secretions	. not individually wrapped . should be wrapped for disposal and transporting

D. Toxic-Shock Syndrome is a rare but serious illness that most often occurs in menstruating women.

Describe Toxic-Shock Syndrome and discuss recommendations for health promotion. See Teacher Background Notes: Toxic-Shock Syndrome.

E. Review/prepare a set of recommendations for safe use of the menstrual products that promote well-being and vaginal hygiene. Examples are:

1. Wash hands before using napkins or tampons.
2. Keep vaginal area clean by regular bathing or washing.
3. Cleanse vulva and anus from front to back to avoid carrying any bacteria from the anus to the vaginal area.

4. Change napkins frequently; wrap and dispose appropriately.
5. Keep menstrual products in a clean bag or container when away from home.
6. Use menstrual products that have low risk:
   - avoid all tampons with Superabsorbent fibers because these may sometimes contribute to Toxic-Shock Syndrome;
   - avoid future use of tampons if you have had Toxic-Shock Syndrome; seek your doctor's advice;
   - ask you doctor or public health nurse about menstrual products;
   - keep up-to-date on information about Toxic-Shock Syndrome and vaginal health
7. Don't use tampons all the time if you are a regular user. Alternate them with napkins during the day and perhaps wear napkins at night.
8. Don't leave tampons in for more than eight hours (change frequently).
9. Be aware of Toxic Shock Syndrome symptoms: FEVER, RASH, MUSCLE ACHES, WEAKNESS, FATIGUE, SEVERE DIARRHEA, and perhaps a feeling of DIZZINESS or FAINTNESS.
10. Stop using tampons and call your doctor if you think you have Toxic-Shock Syndrome or blisters on the vagina area.

F. Encourage students to formulate ideal health practices that adolescent girls should use related to maturation, menstruation, and vaginal health.

III. SUMMARY

Menstruation and ovulation indicate that a female is sexually mature and capable of producing babies. This does not mean she is capable of raising a baby. Many responsibilities accompany maturation. Knowledge about menstruation and practising positive health behavior will assist teens and women to make increasingly wise health choices and become more independent in practising health promotion.

STUDENT STUDY QUESTIONS: THE MENSTRUAL CYCLE - CONTROL AND REGULATION

Student Questions (A)

1. The ovum is located inside a _______________.
2. The lower left hand corner of the diagram shows the lining of the uterine wall being _________________.
3. Between days twelve and sixteen the ________________ ruptures and _________________ an ovum.
4. After ovulation, the wall of the uterus begins to rebuild at a ___________________ rate.
5. If the ovum meets a sperm cell in the fallopian tube ____________ may occur.
6. If an ovum and sperm meet after ovulation, the wall of the uterus is (thick/thin) _______________.
7. The corpus luteum is a specialized group of cells which develop when the uterus is (thickest/thinnest) ______________.
8. If the ovum is not fertilized, the _____________________ and the lining of the _______________ break down.
9. The lining of the uterus and blood flows out of the uterus and through the _______________. The flow is called ______________.
10. Two significant events in the menstrual cycle are the release of an ovum from the _____________ and the thickening of the __________.

Student Questions (B)

1. FSH causes the development of the ________________ in one ovary.

2. As the follicle and ovum develop, the follicle produces __________.

3. The production of estrogen causes the pituitary to produce __________________ which causes the follicle to ________________.

4. After ovulation, the follicle is known as the ___________________ which produces ___________________.

5. The hormone that causes rapid uterine lining growth is __________.

6. Another hormone that influences uterine lining growth is __________________ (produced by the ovary).

7. When estrogen, LH and progesterone production stop, the lining of the uterus is __________________.

8. FSH stimulates the alternate ovary to develop a _________________. The cycle repeats.

9. The menstrual cycle is controlled and regulated by (number) ______________ hormones.

10. The hormones that control ovulation are ____________, ___________; hormones that control uterine wall build-up are ______________ and ________________.

Answers to Questions (A)

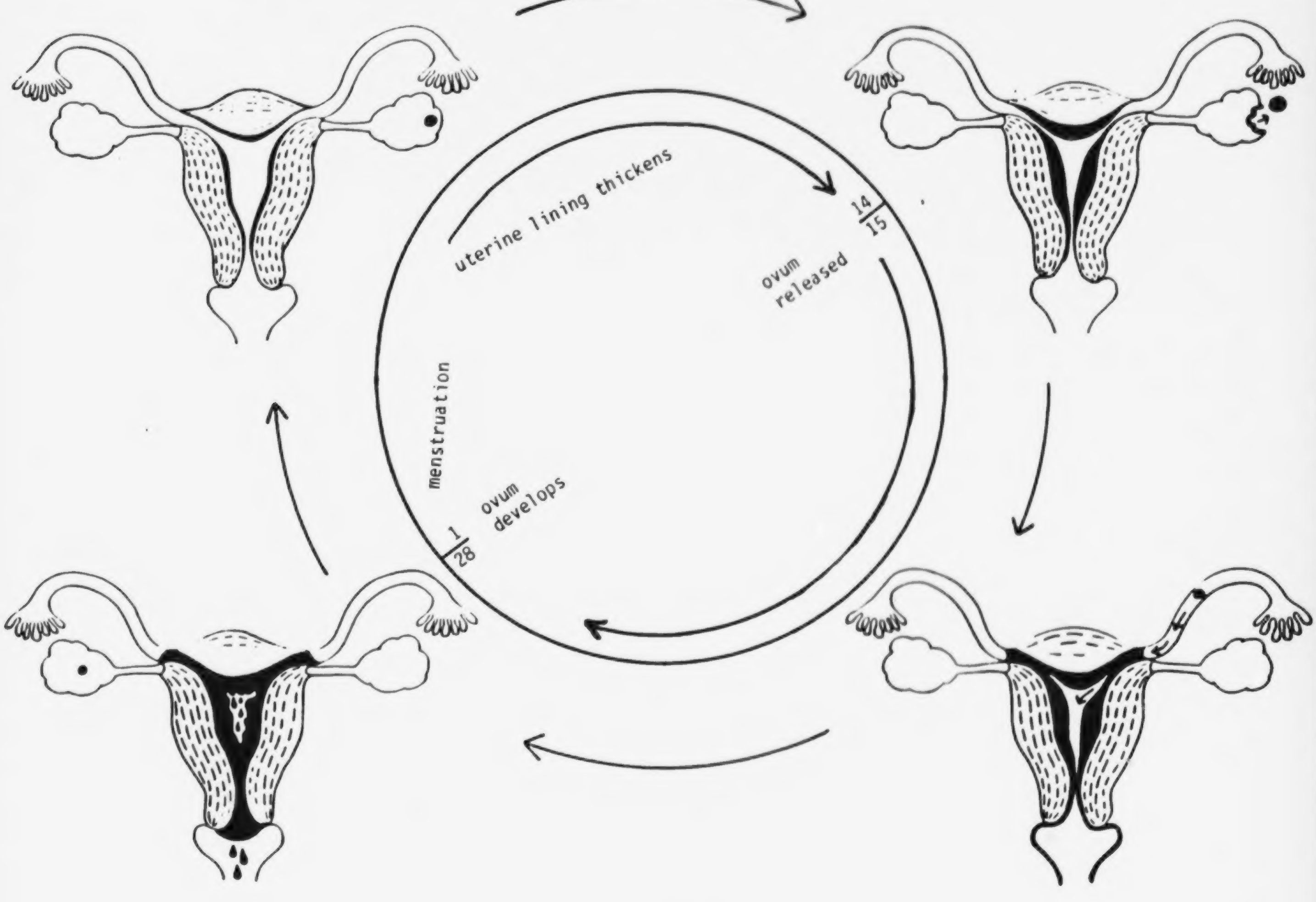
1. follicle
2. sloughed off during menstruation
3. follicle; releases
4. faster
5. fertilization
6. thick
7. thickest
8. corpus luteum; uterus
9. vagina; menstruation
10. ovary or follicle; uterus

Answers to Questions (B)

1. follicle
2. estrogen
3. LH; rupture
4. corpus luteum; progesterone
5. progesterone
6. estrogen
7. shed from the body
8. follicle
9. four hormones
10. FSH and LH; estrogen and progesterone

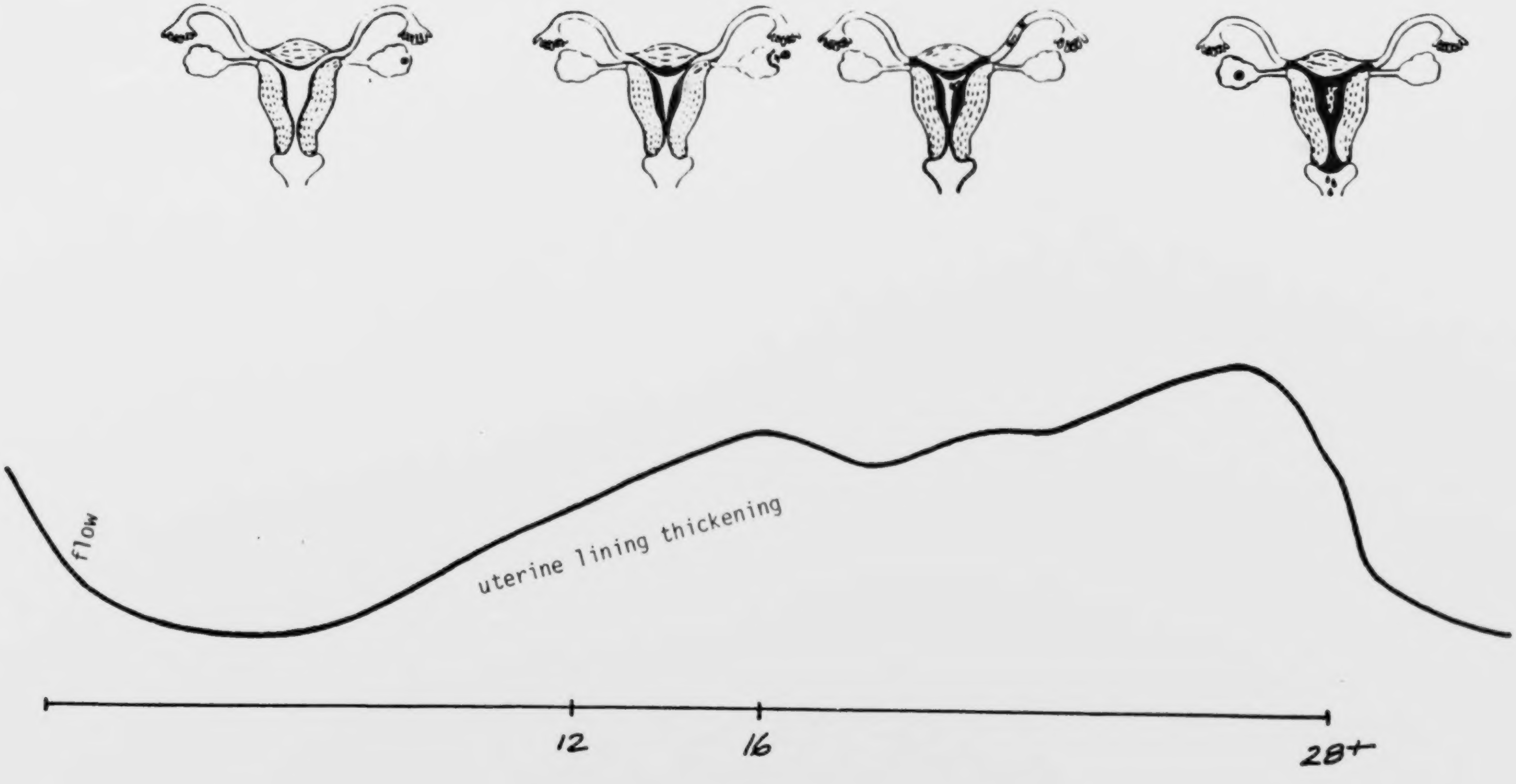
9 2.3
TRANSPARENCY

THE MENSTRUAL CYCLE

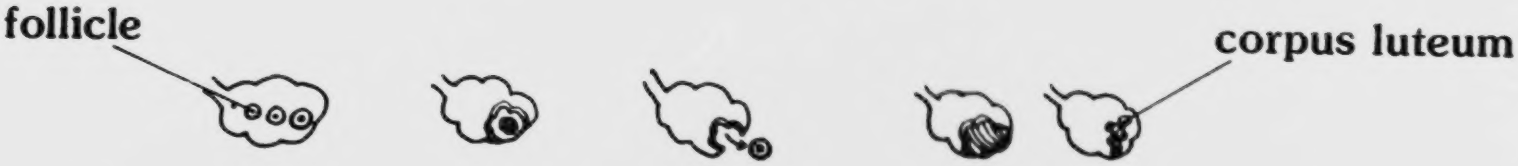

uterine lining thickens
14
15
ovum
released
menstruation
1
28
ovum
develops

9 2.3
TRANSPARENCY

THE MENSTRUAL CYCLE STAGES


flow
uterine lining thickening
12
16
28+

9 2.3
TRANSPARENCY


follicle
corpus luteum

OVUM DEVELOPMENT AND RELEASE

TEACHER BACKGROUND NOTES: THE MENSTRUAL CYCLE: CONTROL AND REGULATION

Girls begin to menstruate approximately every four weeks after they have reached puberty and have become sexually mature. One or the other ovary produces and releases a mature ovum which passes into the fallopian tube. In several days it enters the uterus. The lining of the uterus thickens and develops a rich blood supply. The lining is called the endometrium.

A. Changes

The ovaries and uterus undergo change during the menstrual cycle in response to hormones. The changes are in preparation for receiving a fertilized ovum if fertilization should occur. The uterine lining and ovary changes occur in a regularly established cycle from approximately ages ten to fifty-five when the cycle ceases at menopause; an exception to this is pregnancy.

How does an ovary produce an ovum? Several hundred thousand primary follicles are present in each ovary when a female baby is born. From puberty onward, only about three hundred to four hundred follicles mature throughout life. Each month, or approximately every four weeks, a follicle matures. Inside the follicle is a single sex cell called an ovum.

The follicle enlarges and moves to the outer surface of the ovary producing a bulge. Then the follicle bursts, and the ovum is released. Ovulation has occurred. The remaining cells of the follicle form a structure called the corpus luteum which produces progesterone.

The ovum is conducted into the fallopian tube by cilia which are fine hairs inside the fallopian tubes. The ovum moves towards the uterus. If the ovum is not fertilized, the corpus luteum and the ovum disintegrate. The lining of the uterus breaks down under the influence of hormones and is shed in the menstrual flow. The cycle continues over and over as long as an ovum is not fertilized.

If an ovum is fertilized and implants in the uterine wall, the menstrual cycle stops.

Refer to diagram and overhead, "The Menstrual Cycle."

B. Control and Regulation

What controls ovulation? the building up of the uterine lining?

Chemical substances called hormones are produced in the pituitary and other endocrine glands. The hormones are secreted into the blood and cause other organs and tissues to change (to grow, for example, or produce insulin). At puberty, the pituitary gland begins to produce FSH (follicle stimulating hormone) that causes the ovary to produce and mature follicles. Within each follicle is an ovum. FSH stimulates the follicle to grow, and to produce a hormone called estrogen. The effect of estrogen causes the pituitary to stop FSH production, and the uterus lining to thicken.

At the same time, the pituitary produces LH (luteinizing hormone) which causes the follicle to rupture and release the ovum. The ovum is swept into the fallopian tubes by hair-like structures called cilia.

After the follicle ruptures, the follicle cells change their function. The follicle becomes known as the corpus luteum and, in the presence of LH, the corpus luteum begins to produce progesterone.

Progesterone affects the uterus by speeding up the size and rate of development of the uterine lining. Blood vessels and gland growth increase in the uterus in preparation for a fertilized ovum.

Both estrogen and progesterone encourage uterine lining growth. After the follicle releases the ovum, estrogen production stops. Eventually LH stops as estrogen is no longer produced. The corpus luteum stops producing progesterone as LH stops. When progesterone is no longer produced, the uterine lining breaks down, and menstruation occurs. Then FSH production again begins, and a new follicle, usually from the opposite ovary, begins to develop. The cycle continues.

TEACHER BACKGROUND NOTES: TOXIC-SHOCK SYNDROME

Toxic-Shock Syndrome is a rare but serious illness that most often occurs in young menstruating women. Through extensive investigation in the early 1980's, the medical community has concluded that a significant relationship exists between tampon use during menstruation and the occurrence of Toxic-Shock Syndrome. The distinct feature is the relationship of health practices during the menstrual period--specifically the utilization of tampons with superabsorbent fibers and the manner in which they are used.

Identification: Staphylococcus aureus

Initial Symptoms: rapid onset of high fever, vomiting, profuse diarrhea

Later Symptoms may include sore throat, inflammed eyes, headache, muscular pain and weakness

Within 48 hours the disease progresses and produces:

- a drop in blood pressure (shock)
- a red, sunburned-like body rash
- peeling of skin from the palms of the hands and soles of the feet 7-10 days after onset
- the disease can lead to coma or death if left untreated for too long

Susceptibility

- Young, healthy women who are menstruating, although the disease has been reported to have occurred in non-menstruating women and a small percentage of men

- Young women 15-24 years (56% of all cases reported in 1980; 36% of all cases involved are teenagers 15-19 years)

- Women are at a greater risk if they:
  - insert tampons with fingers rather than inserters or applicators;
  - have had a lengthy vaginal discharge;
  - have had problems with herpes infection

Source and Transmission

- Tampons with superabsorbent fibers are suspected of playing an important role in either helping the bacteria increase in numbers or spreading its toxin.

- Recurrence rates for this disease are high.

Recommendations

PROTECTING MYSELF FROM TOXIC-SHOCK SYNDROME

- Avoid all tampons with superabsorbent fibers.
- Don't leave a tampon in for more than eight hours (change to a new one).
- Avoid wearing tampons all the time. For a few hours out of every 24 (perhaps at night), wear a sanitary napkin instead.
- Wash your hands before inserting the tampon; keep the area around the opening of your vagina clean.
- Be aware of the symptoms of Toxic-Shock Syndrome: FEVER, RASH, MUSCLE ACHES, WEAKNESS, FATIGUE, SEVERE DIARRHEA, and perhaps a feeling of DIZZINESS or FAINTNESS.
- Stop using tampons and call your doctor if you think you have symptoms of Toxic-Shock Syndrome or if you notice blisters on the lips of your vagina.
- If it is possible that you have had Toxic-Shock Syndrome, do not wear tampons for at least the next three periods or until your doctor tells you that you can resume wearing them.
- If you have already had Toxic-Shock Syndrome once, you may want to avoid further use of tampons. Talk to your clinician about this.
- If you have questions, ask your doctor or clinician. Look for information about Toxic-Shock Syndrome in the news.

RESOURCES:

1. Riggs, R.S., and M.P. Noland. "Awareness, Knowledge and Perceived Risk for Toxic Shock Syndrome in Relation to Health Behaviors." Journal of School Health, 53, No. 5 (1983), 303-307.

2. Hatcher, Robert M., et al. Contraceptive Technology. 12th edition. New York: Irvington Publishing, 1984-85.

GRADE 9 **2.0 Human Growth and Development** **Lesson 2.4**

TOPIC

Human Reproduction and the Beginning of Life

STUDENT OBJECTIVES

The student will be able to:

1. identify the implications of ovulation and sexual maturation,
2. describe processes related to reproduction,
3. identify characteristics of the developing embyro and fetus,
4. describe routine health care practices to promote a healthy pregnancy.

SUGGESTED STUDENT OBJECTIVES

- Explain the implications of ovulation and sexual maturation.
- Review the processes involved in the development of new life.
- View characteristics of the embyro and fetus during pregnancy.
- List routine prenatal health practices that promote a healthy pregnancy.

REQUIRED

- Teaching Aids: Student Study Questions: Reproduction;
- CBC Program: "Human Reproduction," The Nature of Things
- Film: "Pregnancy and Birth"; "Human Reproduction"
- Teacher Background Notes: A Human Being Forms; A New Life Begins: Fertilization to Birth

RESOURCES

1. Public health nurse, doctor
2. Meeks, L.B., and P. Heit. Family Living and Human Reproduction. Toronto: Merrill, 1982.
3. Miller, J., and Pelham, D. The Facts of Life: A 3-Dimensional Study. London: Jonathon Cape Ltd., 1984.
4. Life Before Birth. Life Educational Reprint #27. New York: Time, Inc., 1965.
5. "Pregnancy in Anatomical Illustrations," Carnation Incorp., Canada, 1971.

DESCRIPTION OF LESSON

I. INTRODUCTION

Two class periods are required.

DESCRIPTION OF LESSON

This lesson provides information on the reproduction of new life. A great deal of scientific information is available to describe and explain the steps of the development of new life, from how sperm and ova are formed, how they unite to form a fertilized ovum, and how a baby develops before its birth.

You may wish to pretest the class on their background about human reproduction. Provide copies of study questions Human Reproduction, for each student to complete. The test could then be readministered after the course to assess how much students have learned.

II. SUGGESTED STUDENT ACTIVITIES

A. The Beginning of Life

Using audio-visual support, describe pregnancy and fetal development. An alternate presentation would involve discussion of human growth and development using as a reference the Teacher Background Notes: A Human Being Forms.

B. Stages of Fetal Development

Provide copies of pamphlets, books and photographs for class study. Handouts of "A New Life Begins - Fertilization to Birth" may be duplicated for student use. Discuss the key developmental events during pregnancy.

C. Discuss the implications of sexual maturation. Highlight these points:

1. Girls being to menstruate at puberty. This regularly occurring cycle has two significant features: 1) an ovum matures and is released from one ovary, and 2) the uterine wall thickens which occurs in preparation to receive a fertilized ovum. The cycle is controlled and regulated by hormones.

   Generally the ovum is released from the ovary fourteen days or two weeks before the menstrual flow begins. The ovum can be fertilized up to three days after it is released from the ovary.

   Although girls become reproductively mature at the average age of twelve years and are capable of producing new life, they are not capable of raising a child.

2. At puberty, boys begin to produce sperm cells within the testes (testicles). Males, once sexually mature, produce sperm continuously from puberty throughout life. They do not experience a reproductive cycle as females do. Sperm mature within the epididymus and may be released in nocturnal or spontaneous emissions and during sexual intercourse. Nourishing fluids are added to the sperm; the ejaculate is called semen. During sexual intercourse the semen contains 200-400 million sperm cells, any one of which has the ability to fertilize an ovum. Mature sperm cells have a lifespan of 2-3 days. If sperm enter a female's body from 2-3 days before or after ovulation, the ovum could be fertilized.

   Ovulation is often unpredictable. Stress, age, irregular cycles and poor nutrition may influence and change the regular timing of this event. While the most fertile days in the menstrual cycle occur at ovulation, a pregnancy could occur at other times in the cycle.

   The point remains that fertilization cannot occur unless sperm from a male's testes (testicles) reach and enter an ovum inside the female body. Many responsibilities for males and females accompany sexual maturation including regard for societal/family values,religious beliefs and standards, and legalities. While adolescents are capable of reproducing, they are not capable of parenting a child.

D. Invite the public health nurse or a doctor to class to discuss general prenatal care and supervision that promotes a healthy pregnancy.

   Topics to include:

   . fetal development and pregnancy
   . when to seek medical care
   . service and counselling provided by the doctor at prenatal visit
   . prenatal classes provided by public health nurses
   . smoking/alcohol/drugs and pregnancy
   . nutrition/rest/exercise

III. SUMMARY

Human reproduction is a complex process that allows for continuation of life. Many responsibilities must be fulfilled by both parents and family members in order to care for and rear a new family member.

STUDENT STUDY QUESTIONS: REPRODUCTION

1. Rearrange these organs in the correct order for sperm to fertilize an ovum. Begin with the location of sperm production.

   (1) fallopian tube (2) urethra (3) vas deferens (4) vagina
   (5) testes (testicles) (6) epididymus (7) uterus

2. What are the implications of puberty and the production of sperm and ova?

3. When is the beginning of human life? Where does human life first begin? Where does the fetus grow?

4. What key developments have occurred in the developing human baby (embyro) by 8 weeks?

5. What is the length of gestation (pregnancy) for humans? When does a woman feel the baby move?

6. What are the early signs of pregnancy?

7. When should a pregnant woman go to the doctor? What does the doctor do?

8. How do fraternal twins occur? Identical twins?

ANSWERS

1. 5, 6, 3, 2, 4, 7, 1

2. Adolescents become capable of producing new life.

3. When a sperm enters into an ovum; within the fallopian tube; inside the amniotic sac within the uterus.

4. Heart beats, arm, legs, fingers and toes forming; eyes and ears visible; nervous system well-formed - head large with a brain; facial features developing; basic body systems established; all vital organs formed.

5. 280 days or 40 weeks; at 4-5 months when movement of the baby is felt

6. Breasts are tender and enlarged, menstrual period has been missed, possible nausea.

7. As soon as pregnancy is suspected 1-2 months; the doctor will do a history on the woman; do a pregnancy test; do a general and pelvic exam; provide prenatal advice; determine expected birth date.

8. Fraternal twins - occur when 2 ova are each fertilized by a separate sperm - these twins will only be as alike as any sibling
identical twins - result when a fertilized ovum splits into two equal parts in early development resulting in two embryos (babies) - these twins are very alike (sex, tissue type and appearance)

TEACHER BACKGROUND NOTES: A HUMAN BEING FORMS

Each new individual or member of the human species starts life as a fertilized cell, a minute speck with the potential to grow and develop within weeks into a recognizably human form.

The fertilized cell contains two sets of coded instructions that direct its growth and development. At fertilization, twenty-three single chromosomes from the sperm join with twenty-three single chromosomes in the ovum. Among the twenty-three pairs of chromosomes at fertilization, one pair will determine the sex of the new being. Among the twenty-three chromosomes contributed by the ovum is an X (sex) chromosome. The sperm will have either an X or a Y (sex) chromosome. If the ovum is fertilized by a sperm containing an X sex chromosome, the resulting pair is XX or female. If the ovum is fertilized by a sperm containing a Y sex chromosome, the resulting pair is XY or male. The sex of a child, then, is determined by the father's type of sperm cell. The twenty-three paired sets (or 46) chromosomes contain genes which direct the development of the living body of all humans from conception to adulthood.

The function of the reproductive system is to ensure the continuation of life. At puberty, boys' and girls' bodies begin to change under the influence of hormones. In boys at puberty, the male reproductive cells begin to form within coiled tubules inside the testes (testicles). Males develop sperm from puberty throughout life. When born, there are thousands of immature ova within a female's ovaries. At puberty, as the female begins to mature sexually, the menstrual cycle begins. A mature ovum will be released regularly during the menstrual cycle in a process called ovulation. An ovum develops inside a tiny structure called a follicle. Midway through the menstrual cycle, the follicle will have enlarged, moved to the surface of an ovary and released the tiny ovum. It is directed into the fringed fallopian tube by tiny hair-like structures called cilia.

The functions of the female reproductive system are to produce an ovum regularly and to provide a nourishing, supporting home for an anticipated fertilized cell. The function of the male reproductive system is the production and development of sperm.

In order for a new life to develop, a husband introduces sperm into the body of his wife. During sexual intercourse, the erect penis enters the vagina. Ejaculate containing 200-400 million sperm are deposited into the upper end of the vagina and move into the fallopian tubes in search of an ovum. If sexual intercourse occurs around ovulation, when the female is most fertile, and a sperm enters the ovum, fertilization occurs.

The long process of 40 weeks of development has begun within the mother's body.

The fertilized cell undergoes growth by cell division (mitosis). One cell divides into 2, then 4, 8, 16, 32, 64. By the time 64 cells are produced (in several days), the cells have become arranged into a hollow ball called a morula. Four to five days after fertilization in the fallopian tube, the morula moves into the uterus where it embeds in the soft uterine lining. Part of the structure will develop further into an embryo while part of the structure will develop into the placenta, umbilical cord and membranes that surround the new life.

Nourished and supported within the uterus, the embryo develops day by day. The new life is called an embryo until the end of two months. Rapid growth occurs in the embryo. Cells differentiate into different tissue types and key organs and body systems begin to develop. The embryo is enclosed within membranes that form the amniotic sac and is cushioned by the amniotic fluid in the sac. Within the first month, the heart has begun to beat within a tiny human structure, now 1 cm in length. By two months, key organs have developed; the brain and heart are mostly developed; fingers, toes, arms and legs are identifiable; facial features are well begun; ears and eyes are forming; the sex of the embryo can be determined; and the digestive system is forming.

After two months, the developing embryo is called a fetus. At this time, the placenta has developed into an efficient organ that nourishes the developing fetus and removes its wastes. Blood pumped by the fetal heart, circulates through the umbilical cord to the placenta and back. The maternal and fetal blood are separated in the placenta by a layer of cells through which nutrients and oxygen from the mother diffuse to the fetus; wastes diffuse from the fetus to the mother for removal. The placenta provides nourishment, waste removal, support and protection until the fetus is full term.

Prenatal care should be sought early to ensure the healthiest possible baby. After the first menstrual period is missed or pregnancy is suspected, a woman should visit her family doctor. He/she will complete a history of the woman, perform a general examination, including a pelvic examination, have a pregnancy test carried out, provide prenatal advice and determine the expected birth date. Follow-up visits will be planned to supervise the health of the pregnant woman and her developing fetus.

Gestation for humans is 40 weeks. Growth and development are most rapid in the early weeks of pregnancy. At full term (40 weeks), the average fetus may be 46-56 cm (18-20 inches) long, and have mass of 3-4 kg (weigh 7 lbs.). At birth, the baby can survive without its life-support system.

Labour is a three-stage process. The first stage is characterized by the opening of the cervix. Muscular contractions begin to open the cervix so that the head of the fetus moves downward into the birth canal. The amniotic sac in which the fetus floated for so many months, breaks and the waters drain. During the second stage of labor, muscular contractions force the fetus through the birth canal. Medical attendants, doctor and/or nurse, and often the father encourage and assist the mother in the safe delivery of the newborn baby into the world.

From the moment of birth, the newborn baby no longer needs oxygen supplied by the placenta. The umbilical cord is clamped and later cut. In a few days the cord will dry and fall off, leaving a scar known as the naval or belly button.

The third stage of birth is marked by the loosening of the placenta from the uterine wall and its expulsion from the mother's body. It is commonly called the afterbirth.

The time of labor varies. It may be longer for mothers who are pregnant for the first time. Usually 2-4 days are spent in hospital following delivery.

The family welcomes the newborn member home. Many responsibilities accompany the joy of parenthood and family living.

RESOURCES:

1. Parker, S. Life Before Birth. Cambridge: Cambridge University Press, 1979.
2. ISIS. Human Reproduction. Lexington, MA: Ginn and Co., 1981.
3. ISIS. Birth and Growth. Lexington, MA: Ginn and Co., 1977.
4. Miller, J., and Pelham, D. The Facts of Life: A 3-Dimensional Study. London: Jonathon Cape Ltd., 1984.

A NEW LIFE BEGINS - FERTILIZATION TO BIRTH

TIME	APPROXIMATE SIZE	DEVELOPMENT
1st Day	Smaller than this dot •	The egg cell and sperm cell combine to form a single cell with 46 chromosomes.
7 Days	About the size of this dot •	The group of cells attach to the uterine lining. It is now called an embryo.
1 Month	Length: 0.6 centimeters	The heart begins to beat. The nervous and digestive systems form. The eyes and ears are visible.
2 Months	Length: 2.5 centimeters	The embryo has a large head with a brain and facial characteristics. The fingers and toes appear. The embryo is called a fetus.
3 Months	Length: 7.5 centimeters	The face is clearer. The first signs of the sex of the fetus appear. The excretory system develops rapidly.
4 Months	Length: 15 centimeters	The fetus kicks its legs and moves its arms. The skin develops.
5 Months	Length: 25 centimeters	The rate of growth slows. Fine hair develops. The mother and doctor can listen to the fetal heart rate by using an instrument called a stethoscope. The fetus can suck its thumb.
6 Months	Length: 30 centimeters	The fetus moves more often. The eyes are open. Outside sound or pressure can increase fetal heartbeat.
7 Months	Length and weight vary	The fetus is fully developed but does not have enough fat cells to control body temperature. Will need to be in an incubator if born. Greatest change in length and weight occurs during this month.
8 and 9 Months	Length: 46 to 56 centimeters Weight: 2.5 to 3.5 kilograms	The organ systems complete their development. Fat cells form on the body. The baby is born.

From Family Living and Human Reproduction (Columbus, OH: Charles E. Merrill, 1932), pp. 38-39. Used with permission.

TOPIC

Adolescence: Turbulent or Carefree Years?

STUDENT OBJECTIVES

The student will be able to:

1. identify life-events that cause stress for adolescents,
2. determine the stress value of a list of life-events,
3. interpret tables from an article about life-events that cause adolescent stress.

SUGGESTED STUDENT ACTIVITIES

- Prepare a list of life-events perceived by students as stressful and rank each event from 0-5; then tabulate class data to illustrate perceived stress value for each event.
- Complete a worksheet individually and then tabulate class data to illustrate stress value for each event.
- Report key findings from an article that describes stressful life-events of Canadian youth.

REQUIRED MATERIALS

- Teaching Aid: Youth Adaptation Rating Scale
- Teacher Background Notes: "Adolescents Face Stressful Changes"

RESOURCES

1. Health and Welfare Canada. "Adolescents Face Stressful Life Changes." Health Education. Fall, 1982.
2. Beall, S., and G. Schmidt. "Development of a Youth Adaptation Rating Scale." Journal of School Health, 54, No. 5 (1984), 197-202.

DESCRIPTION OF LESSON

I. INTRODUCTION

Adolescence is an important life stage of physical, emotional, intellectual and social change. Adolescence has been identified as a very stressful stage of development due to the identity crises and life events which may or may not be under the control of the individual (death in the family, moving to a new school, being pressured to take drugs).

DESCRIPTION OF LESSON

The adolescent years are sometimes, inappropriately, referred to as carefree, worry-free and responsibility-free years. For many, this may not be true. It is important that students, parents and teachers be aware of the type of events that cause stress in the lives of young people who should learn how to deal with these life events in a healthier way. The effects of stress can be felt immediately or later in life. Many of these effects may be prevented or may be amenable to change through the adoption of positive health practices.

II. SUGGESTED STUDENT ACTIVITIES

A. Have students define adolescence.

1. Brainstorm a list of life-events that cause stress for adolescents. Have each student rank the event on a 0 to 5 scale as described below in the table. Determine the value of each event, then tabulate the class data. Arrange events in sequence.

TABLE 1

Categories for Describing Degrees of Adaptation

5 = Critical event in the life of a teenager; very stressful. Totally demanding. This would require a major change in one's life.

4 = Semi-critical event. Stressful. This would require a significant adjustment in one's life.

3 = Moderately critical. This event causes stress, but does not require too great a change in one's life.

2 = Semi-moderate. Stress is evident, but the event does not require a difficult adjustment or involve a great deal of mental, emotional or physical strain.

1 = Mild stress. Hardly any stress at all. This would require minor changes without much effort.

0 = Not stressful at all. This would probably require no change at all.

Source: JOSH, 54 (No. 5) (1984), 197. Used with permission .

DESCRIPTION OF LESSON

2. You may wish to have students complete an inventory using the worksheet Youth Adaptation Rating Scale provided in the Teaching Aids. Determine class values for each event and arrange events in a sequence.

Note to Teacher: To determine class values, have each student rate the events from 0-5 using the above table. Then determine the class rating as follows: if there are 30 students rating a list of items from 0-5, the highest possible score for each item would be 5 x 30 = 150. The total of the 30 students' rating for any item would be divided by 150 to attain the value for that item. The value indicates the adaptation required to cope with each event as perceived by the class.

B. Divide the class into small study groups. Provide copies of the article, "Adolescents Face Stressful Life Change ." Have students read the article for key points and interpret the tables below:

Table 1 - Number of Adolescents aged 12-17 years in Canada 1970 to 1980.

Table 2 - Death Rates Among Adolescents aged 12-17 for all causes, Canada 1980

Table 3 - Percent Distribution of Hospital Days by selected ICDA, 8 chapters by age and sex, Canada 1978

The teacher should provide assistance to student groups in reading the article and interpreting the tables. The article is likely above the reading level of the average grade 9 class.

C. Select from the list below, or use those selected by the local Family Life Education committee, those topics of interest. These will form the lessons for the 3.0 Dilemmas and Issues section of the grade 9 program.

- dating
- sex-role stereotyping
- teenage pregnancy prevention: postponing sexual involvement
- teenage pregnancy: risks, consequences and prevention
- solving problems assertively
- sexually transmitted diseases
- sexual assault (rape) prevention
- drugs and pregnancy
- divorce

DESCRIPTION OF LESSON

III. SUMMARY

Parents, teachers and adolescents may not perceive adolescence as a turbulent time, full of stressful events that require adaptation.

Youth, parents and teachers can benefit from the identification of types of life events that cause stress to adolescents and the amount of adaptation required to cope with stress. Coping skills and strategies may be developed to assist young people in dealing with stressful events, such as problem solving, stress management, assertiveness, to prevent the onset of serious health consequences.

By being knowledgeable of health issues and the consequences of health-risking behavior, adolescents can become more independent in making wise health decisions that extend the length and increase the quality of their own lives.

YOUTH ADAPTATION RATING SCALE

_ Graduation
_ Pet Dies
_ Fights with Parents
_ Getting Pressure About Having Sex
_ Caught Cheating or Lying Repeatedly
_ Getting a Major Illness/Injury/Car Accident
_ Becoming Religious or Giving Up Religion
_ Referral to the Principal's Office
_ Getting Acne/Warts
_ Trouble Getting a Date When It Was not a Problem Before
_ Problems Developed with Teachers/Employers
_ Making Career Decision (College, Majors, Training, etc.)
_ Starting to Go to Weekend Parties/Rock Concerts
_ First Day of School
_ Going on First Date/Starting to Date
_ Death of a Parent/Guardian
_ Not Getting Promoted to Next Grade
_ Getting Caught Using Drugs
_ Getting Attacked/Raped/Beaten Up
_ Getting a Ticket or Other Minor Problems with Law
_ Parents Getting a Divorce/Separation
_ Getting Expelled/Suspended
_ Fad Pressure
_ Breaking Up with Boy/Girlfriend
_ Getting Minor Illness (Cold, Flu, etc.)
_ Arguments with Peers/Brothers/Sisters
_ Starting to Perform (Speeches, Presentations, Musical or Drama Performances)
_ Getting Fired From a Job
_ Going into Debt
_ Being Stereotyped/Discriminated/Having Bad Rumors Spread About
_ Death of a Close Family Member
_ Death of a Boy/Girlfriend/Close Friend
_ Getting V.D.
_ Getting Someone Pregnant/Getting Pregnant
_ Taking Finals
_ Moving To a Different Town/School/Making New Friends
_ Getting a Car
_ Trying to Get a Job/Job Interview
_ Getting an Award, Office, etc.
_ Making a Team (Drill, Athletic, Debate)
_ Getting Married
_ Getting Beat Up By Partners
_ Taking the Driver License Test
_ Getting a New Addition to the Family
_ Going to the Dentist or Doctor
_ Going to Jail/Reform School
_ Starting to Use Drugs
_ Getting Braces
_ Going on a Diet
_ Losing or Gaining Weight
_ Changing Exercise Habits
_ Pressure to Take Drugs
_ Moving Out of the House
_ Falling in Love
_ Getting a Bad Haircut
_ Getting Glasses
_ Family Member Moving Out
_ Getting a Bad Report Card

Souce: JOSH, 54, No. 5 (1984), 198. Used with permission.

5 = critical event; 4 = semi-critical event; 3 = moderately critical;
2 = semi-moderate; 1 = mild stress; 0 = not stressful at all

TEACHER BACKGROUND NOTES

Adolescents face stressful life changes

Lifestyle related health behaviours among adolescents explored

This paper was prepared by the Health Promotion Studies Unit of the Health Promotion Directorate, Health and Welfare Canada.

Adolescence is an important life cycle stage of physical, psychological and social change. Often the changes are associated with stressful events. Early adolescence, ages 12 to 14, is marked by the transition from elementary to high school. Later adolescence, ages 15 to 18, is a period of transition from high school to post-secondary education or to entry into the labour force.

During adolescence, young people try out different behaviours, some of which are risky and may lead to unfortunate consequences. Some behaviours may affect health immediately, such as a car accident related to alcohol use, or contracting a venereal disease. Other behaviours produce their harmful effects later in life — for example, smoking-related diseases such as lung cancer and cardiovascular disease.

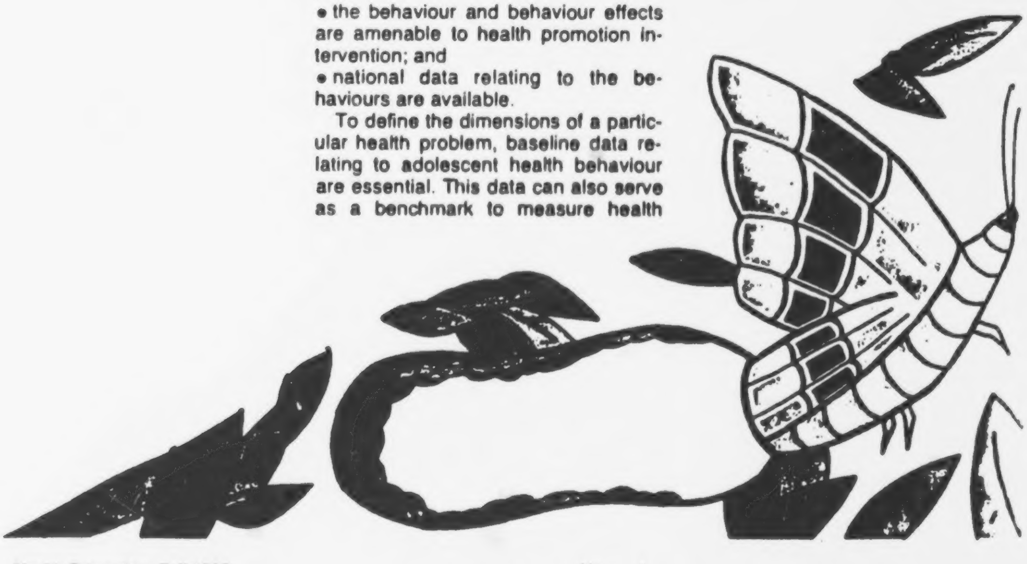
For these reasons, many organizations, including Health and Welfare Canada, have targeted adolescents for special attention in health promotion programs. The following paper presents information on selected lifestyle related health behaviour among Canadian adolescents. The health behaviour and behaviour outcomes — teenage pregnancy, abortion, venereal disease, and use of alcohol, marijuana and tobacco — were selected for a number of reasons:

- these behaviours place adolescents at possible immediate and long-term risk;
- the behaviour and behaviour effects are amenable to health promotion intervention; and
- national data relating to the behaviours are available.

To define the dimensions of a particular health problem, baseline data relating to adolescent health behaviour are essential. This data can also serve as a benchmark to measure health promotion efforts. For this paper, statistics relating to Canadian adolescents were obtained from a number of sources — Canada Census, vital statistics, hospital morbidity statistics, the Canada Health Survey, the Canada Fitness Survey, and special surveys conducted by government departments. However, the data obtained from these sources are not always tabulated for the same age groups. In this paper, data are presented where possible for the population between the ages of 12 and 17.

Population at risk

The age structure of a population is determined by historical trends in fertility, mortality and migration. Fertility change has by far the greatest effect on the age composition. Adolescents who were a product of the post World War II baby boom were important for social and political reasons due to the unprecedented increase in their numbers. In Canada, the baby boom lasted until 1961. The peak birth cohorts from the baby boom have already passed through the adolescent age groups and since 1978 there has been a progressive decline in the size of the adolescent population (*Table 1*).* In 1979, there were 2 635 800 adolescents in Canada between the ages of 12 to 17. By 1981, the number declined to 2 485 800. It is projected that by 1990 there will be approximately 2 214 700 adolescents.



The declining adolescent population at risk has implications for health promotion programs. Even if the proportion of the adolescent population engaging in a negative health behaviour remained the same, its absolute size would still decline due to the diminishing population base. In addition, a reduction in the prevalence rate for a negative health behaviour would result in a more accelerated decline in the absolute number of adolescents at increased risk.

When evaluating health promotion programs, therefore, it is essential to take into account two trends: the trend of age-specific incidence or prevalence rates prior to the program intervention; and the changing age distribution of the population.

Adolescent pregnancy

In absolute numbers, live births to adolescents age 12 to 17 declined from 42 574 births in 1970 to 31 273 in 1980. There has been a relative decline in age-specific birth rates in the order of 30 per cent for the 15-to-17-year-old age group and 39 per cent among 18-to-19-year-olds. Birth rates for the 10 to 14 age group remained stable. The percentage of all births to women under age 20 declined from 12 per cent in 1970 to six per cent in 1980. Births to women under age 18 represented four per cent of all births in 1970 and three per cent in 1980.

The decline in birth rates among the two older age groups may reflect increased awareness and use of contraceptives and/or the effect of abortion services on the rates. Data from the Canada Health Survey indicate that approximately nine per cent of 15-to-17-year-olds and 29 per cent of 18-to-19-year-olds use birth control pills. The proportion using birth control pills is not a reliable indicator of the proportion of adolescent females who are sexually active.

Some limited data relating to the sexual behaviour of Canadian adolescents is found in a report by Badgley. His study concluded that the proportion of adolescent females who had coitus once a week or more often was 2.8 per cent for females age 15 years and nine per cent for those between 16 and 17. Adolescent females who indicated that they had coitus were unlikely to use contraception. The proportion of sex-

Table 1

Number of adolescents aged 12-17 in Canada
1970-1988

Year	Total	12-15 yrs.	16-17 yrs.
1970	2,635.8	1,784.1	851.7
1971	2,686.5	1,816.8	869.7
1972	2,725.4	1,839.2	886.2
1973	2,759.4	1,866.8	892.6
1974	2,792.0	1,883.5	908.5
1975	2,825.5	1,901.6	923.9
1976	2,842.8	1,897.5	945.3
1977	2,830.4	1,863.2	967.2
1978	2,770.7	1,811.4	959.3
1979	2,679.4	1,731.8	947.6
1980	2,588.8	1,643.6	945.2
1981	2,485.0	1,564.6	920.4
1982	2,417.7	1,540.6	877.1
1983	2,354.4	1,527.7	826.5
1984	2,301.8	1,517.1	784.7
1985	2,262.2	1,502.8	759.4
1986	2,237.7	1,471.1	766.6
1987	2,229.2	1,449.9	779.3
1988	2,209.3	1,447.9	761.4
Relative per cent change 1970-1988	-16.2%	-18.8%	-10.6%

Source: Statistics Canada, Demography Division, Intercensal Estimates of the Population by Age and Sex, 1970, 1972, 1973, 1974, 1975, 1977, 1978, 1979, 1980, 1981. Enumerated Population of Canada by Age and Sex, 1971, 1976. Statistics Canada, Population Projections for Canada and the Provinces 1976-2001, Catalogue 91-520 Occasional. Projection number three was used for 1982-1988.

Table 2

This table indicates the death rates among adolescents aged 12-17 for all causes, including accidents and violence, and diseases and conditions. The per cent of deaths due to selected specified causes by age (Canada, 1980) is also presented.

Cause of death	Total 12-17 yrs.	12-15 yrs.	16-17 yrs.
Deaths per 10,000 population			
All causes	5.8	4.2	8.6
Accidents and violence	4.2	2.7	6.9
Diseases and conditions	1.6	1.6	1.7
Per cent of deaths due to specified cause			
All causes	100.0	100.0	100.0
Accidents and violence	72.2	63.2	79.9
accidents	61.2	55.2	66.3
motor vehicle	41.9	32.7	49.8
fires	2.5	3.3	1.8
drowning	3.7	4.7	2.8
homicide	1.1	1.1	1.0
suicide	8.8	5.7	11.5
Diseases and causes	27.8	36.8	20.1
Malignant neoplasms	8.2	10.7	6.0
neoplasms lymphatic & haemotopietic tissue	3.4	4.6	2.3
Nervous system	3.7	5.3	2.3
Respiratory System	2.6	3.6	1.7
Pneumonia and influenza	0.9	1.3	0.6
Circulatory system	4.2	4.2	4.3
Infective and parasitic	0.1	0.1	-

Source: Special tabulations, Health Division, Statistics Canada ually active women not using contraception was 33 per cent for women age 15 and 17 per cent among those age 16 to 17. The sample consisted of 4 189 respondents age 15 and over. There were 554 adolescents between the age 15 and 17.[1]

Childbirth at any age is a major event in the life of a woman. The social implications of the birth of a baby to an adolescent mother have been aptly described by Campbell.[2]

> "The timing of the first birth is of crucial strategic importance in the lives of young women, because the need to take care of a baby limits severely their ability to take advantage of opportunities that might have changed their lives for the better. In this regard, the problems posed by births to unmarried mothers are especially serious. The girl who has an illegitimate child at the age of 16 suddenly has 90 per cent of her life's script written for her. She will probably drop out of school, even if someone else helps to take care of the baby, she will probably not be able to find a steady job that pays enough to provide for herself and her child; she may feel impelled to marry someone she might not otherwise have chosen. Her life choices are few, and most of them are bad. Had she been able to delay the first child, her prospects might have been quite different . . ."

It has been argued that the decline in live births among adolescents does not necessarily result in a reduction in the number of adolescent mothers because a larger proportion of young mothers keep their babies. In 1971, approximately 30 per cent of young mothers took their babies home compared to 85 per cent in 1981.[3] In addition, the proportions of married teenagers declined steadily between 1965 and 1979. In 1970, approximately one third of pregnant women less than 20 years of age were unmarried at the time of delivery but, by 1978, this proportion had risen to 50 per cent.[4]

Some indirect evidence relating to the implications of adolescent pregnancy may be found in Statistics Canada tabulations relating to census families in private households. If increasing proportions of adolescent mothers are opting to keep their babies and pregnancy is less of an inducement to marriage, the trend should and in fact is reflected in an increase in the number of lone parent families headed by 'never married' females.

Between 1971 and 1981, the total population of Canada increased 12.5 per cent, the number of census families in private households increased 24.7 per cent and lone parent families headed by females age 15-24 increased 97 per cent. When lone parent families were examined by age of mother, families headed by females age 15 to 17 decreased by four per cent, while lone parent families headed by females age 18 to 19 and 20 to 24 more than doubled.

The distribution of female lone parent families by marital status changed substantially between 1971 and 1981. The proportion of female lone parents in the 15 to 17 age group who reported that they were 'never married' in 1971 was 79 per cent compared to 88 per cent in 1981. In the 18 to 19 age group, 59 per cent of lone parents indicated that they were never married in 1971 compared to 80 per cent in 1981. The proportion 'never married' in the 20 to 24 age group was 25 per cent in 1971 and 58 per cent in 1981.

The reader is cautioned that a number of demographic and sociological variables ultimately influence the number of lone parents. These include fertility, abortion, migration, marriage, divorce, separation and the decision by the mother to keep a baby.

The health consequences of adolescent pregnancy affect both the mother and the child. An adolescent mother, especially one under age 17, faces numerous health risks.[5,6,7,8] Pregnancy can stop her growth and reduce her adult height. Hypertension, toxemia, pre-eclampsia, eclampsia, post-partum hemorrhage, forceps delivery and maternal mortality are complications for which the young mother is at greater risk. Research comparing obstetrical risks among younger and older women shows a consistent advantage to women in their twenties compared to teenagers and women over age 35. A number of the health risks associated with teenage pregnancy can be reduced through good nutrition and early continuing pre-natal care. Other studies suggest that subsequent births by adolescent mothers occur more frequently and in shorter time intervals than among older mothers.[9,10,11]

The increased health risks to the baby of an adolescent mother may be the most important medical aspect of teenage pregnancy. These risks include prematurity, a higher incidence of low birth weight, and higher infant morbidity and mortality. For all birth orders combined, the infant mortality rate among infants of teenage mothers is 28 per cent above the average for offspring of mothers age 20 to 34.[12] Girls who conceive within two years of menarche are twice as likely to produce a low birth weight baby as those who conceive later.

The size of the perinatal and neonatal death rates in a population depends in large measure on the frequency of low weight births.[13] In Canada, data for 1980 indicate that about eight per cent of the babies born to mothers below the age of 20 were less than 2500 grams. Approximately six per cent of all births were less than 2500 grams. The post-neonatal death rates of babies born to young adolescent mothers also tend to be higher. This relationship probably reflects the young mother's experience in meeting the needs of the newborn.[14] A wide range of neurological and sensory handicaps are associated with low birth weight.[15]

Abortion

Since the legalization of abortion in Canada in 1969, the total number of legal abortions among adolescents has increased steadily. The most recent data (1980) reveal that a total of 9128 adolescent females obtained legal abortions. Of these adolescents 1988 were age 12 to 15 and 7160 were age 16 to 17. A review of Canadian statistics relating to the 1974 to 1978 period noted that the abortion rates for adolescents are lower in Canada than in most of the developed countries for which data relating to legal abortions are available.

Adolescents are at much higher risk for complications resulting from abortion procedures because they tend to seek medical advice at a later point in the gestation process. Between 1974 and 1978 more than 25 per cent of teenagers undergoing an abortion were more than 12 weeks pregnant at the time of the abortion, in contrast to only 15 per cent of the women over 19 years of age.[16]

The strong inverse relationship between the period of gestation at the time of the abortion and the age of women probably reflects the adolescent woman's inexperience in recognizing the symptoms of pregnancy, her reluctance to accept the reality of the situation, her ignorance about where to seek advice and help and her hesitation about confiding in adults.[17]

Sexually transmitted diseases

Sexually transmitted diseases are also adverse consequences of sexual activity. The official government statistics on sexually transmitted diseases seriously underestimate the actual incidence levels. In 1980, sexually transmitted diseases accounted for 60.5 per cent of the total reported notifiable diseases in Canada.

The most common of the sexually reported diseases is gonorrhea. The case rate for 15-to-19-year-olds in 1980 was 434 per 100 000. The rate for females (539.4) was higher than the rate for males (331.4). The higher rate for females may be due to the greater likelihood of young females being named as a contact by older men.[18]

The implications of infection are serious. Among females, pelvic inflammatory disease and the consequent risk of sterility through scarring of the fallopian tubes are important health consequences. In recent years, the treatment of diagnosed cases of gonorrhea has been made more complicated by the appearance of several strains of neisseria-gonorrhea which are highly resistant to penicillin.[19]

Use of tobacco, alcohol and marijuana

Cigarette smoking among Canadian adolescents is an important health promotion issue. Data relating to smoking behaviour among adolescents may be found in the Labour Force Survey supplements on smoking and special surveys commissioned by Health and Welfare Canada. Between 1966 and 1981, the proportion of regular smokers in the population age 15 to 19 decreased from 35 per cent to 23 per cent for males. Trends in the proportion of regular smokers among 15-to-19-year-old females differed from the trend for adolescent males. Between 1966 and 1972, prevalence rates for 15-to-19-year-old girls increased from 20 per cent to 28 per cent and then declined slowly to 23 per cent in 1981. Adolescent girls now have the same smoking rate as adolescent boys.

In May 1982, a national survey of 1544 Canadians between the ages of 12 and 19 was carried out by the Canadian Gallup Poll for the Health Promotion Directorate. The sampling procedure was designed to yield a representative population. The survey found that the smoking behaviour of Canadian adolescents closely parallels the smoking behaviour of adults in the region in which they reside. Approximately eight per cent of the 12 to 14 age group and 26 per cent of the 15 to 17 age group reported that they smoked cigarettes daily.

Approximately 56 per cent of the sample between the ages of 12 and 17 reported that they had consumed alcohol during the year preceding the survey. Forty three per cent claimed that they had used alcohol within the past month and 13 per cent reported use of alcohol in the week prior to the survey. However, responses to questions regarding use in the past year, month, or week do not necessarily measure hazardous use. Daily use is one indicator of a higher risk consumption pattern. About one per cent of the 15-to-17-year-olds reported daily use of alcohol.

While there have been a number of regional studies on marijuana use among Canadian adolescents, there have been few national surveys. There are indications, however, from surveys carried out between 1980 and 1982 that marijuana use by Canadian adolescents may be declining. The trends in reported use of marijuana should be interpreted with caution as respondents are being asked to self-report on an illegal behaviour. The trend may reflect the willingness of respondents to admit to engaging in deviant behaviour.

Among the 15-to-17-year-old age group, in 1980, 33 per cent indicated that they had "ever used" marijuana compared to 38 per cent in 1981 and 29 per cent in 1982. The proportion of 15-to-17-year-olds reporting daily use in 1982 was about two per cent of the population. The estimates of substance use by adolescents would imply that 25 500 adolescents in this age group smoke marijuana on a daily basis. Approximately 12 800 consume alcohol on a daily basis and 332 500 smoke cigarettes on a daily basis.

Table 3

Per cent distribution of hospital days by selected ICDA — 8 chapters age and sex, Canada, 1978

	Selected ICDA chapters	12-14 yrs.		15-17 yrs.		12-17 yrs.	
		Number	%	Number	%	Number	%
	Males						
	Total Hospital Days	215,248		293,115		508,363	
	All Diagnosis						
I.	Infective	6,843	3	7,667	3	14,510	3
II.	Neoplasms	5,910	3	8,233	3	14,143	3
V.	Mental Disorders	18,916	9	36,844	13	55,760	11
VIII.	Respiratory	21,296	10	20,926	7	42,224	8
IX.	Digestive	22,844	11	28,452	10	51,296	10
XIV.	Congenital	9.952	5	9.436	3	19,388	4
XVII.	Accidents	58.227	27	98,352	34	156,579	31
	All other Diagnoses	71,258	33	83,205	28	154,463	30
	Females						
	Total Hospital Days	208,227		388,096		596,363	
	All Diagnosis						
I.	Infective	10,440	5	9,340	2	19,780	3
II.	Neoplasms	5.581	3	9,854	3	15,435	3
V.	Mental Disorders	22,483	11	45,076	12	67,559	11
VIII.	Respiratory	23,218	11	29,330	8	52,548	9
IX.	Digestive	19,041	9	31,299	8	50,340	8
XI.	Complications of Pregnancy, Childbirth and Puerperium	8,757	4	93,069	24	101,826	17
XIV.	Congenital	11,047	5	9,813	2	20,860	3
XVII.	Accidents	28,142	14	45,746	12	73,888	12
	All Other Diagnoses	79,518	38	114,569	29	194,127	33

Due to rounding the total may not total exactly 100 per cent.
Special Tabulation provided by Institutional Care Statistics, Health Division, Statistics Canada.

Mortality and morbidity

Mortality in late childhood and early adolescence is fairly low. In 1980, the death rate for adolescents age 12 to 17 was six per 10 000. Accidents, poisoning and violence are the most important causes of death in adolescence, accounting for 72 per cent of all deaths within this age group. Among adolescents age 16 to 17, the proportion of all deaths attributable to accidents reaches 80 per cent (*Table 2*).

Motor vehicle accidents are responsible for 42 per cent of all adolescent deaths and represent 68 per cent of accidental deaths. Adolescent males are at much higher risk. Approximately 73 per cent of all adolescent deaths from accidents, poisoning and violence occur among the male population. Suicides represent approximately nine per cent of all deaths among adolescents and 11 per cent of all deaths in the 16 to 17 age group. Between 1970 and 1980, the suicide rate for boys age 15 to 19 increased from 10.1 to 19.5 per 100 000 — a relative increase of 93 per cent.

Diseases and conditions other than accidents, poisoning and violence are responsible for 28 per cent of adolescent deaths. Malignant neoplasms are the most important disease conditions accounting for eight per cent of all deaths.

Insofar as such a large proportion of adolescent deaths are a result of motor vehicle accidents, the failure to use seatbelts takes on special importance. Data from the 1978/79 Canada Health Survey indicate that in the general population age 15 years and over, 55 per cent of automobile drivers claimed that they used a seatbelt "always or most of the time". Only 34 per cent of adolescents between the ages of 15 and 17 used seatbelts most of the time. The proportion of seatbelt users in the 18 to 19 age group was 45 per cent. There was a higher proportion of unknowns in the 15 to 17 age group and this may have contributed to some of the variance in reported seatbelt use between younger and older adolescents. Males were slightly more likely to wear seatbelts than females.

Adolescents were slightly more likely to wear a seatbelt while riding as a passenger in a car than riding as a driver. However, they were still less likely to wear a seatbelt as a passenger than the general population. About 43 per cent of adolescents age 15 to 17 claimed to use a seatbelt while riding as a passenger compared to 50 per cent of the population age 15 and over.

Morbidity as measured by the utilization of acute care hospital services (*Table 3*) paralleled the most common causes of mortality among adolescents. Approximately 21 per cent of all hospital days for adolescents, 31 per cent for males and 12 per cent for females, were attributable to accidents. Mental disorders accounted for 11 per cent of all hospital days in the 12 to 17 age group.

Special tabulations relating to the use of psychiatric hospital services in 1978 were provided by the mental health division of Statistics Canada. A total of 1 192 612 days were used by adolescents age 12 to 17, adolescents age 12 to 14 utilized 466,539 days and those age 15 to 17 utilized 729 073 days. Utilization rates were higher for males than females. In the 12 to 14 age group, patients' days were 454 per 1000 for males and 241 per 1000 for females. Within the 15 to 17 age group, the utilization rates were 864 per 1000 for males and 447 for females.

Conclusion

This paper has presented some selected data which suggest that Canadian adolescents engage in lifestyle related behaviour that place them at increased risk in both the short and long term. Many of the behaviour patterns that contribute to the aetiology of chronic diseases are established during adolescence. By promoting preventive behaviour during the adolescent years, gains can be made in extending the length and quality of life.

**This paper was prepared with more tabular data than could be published. To receive this data, contact the Health Promotion Studies Unit, Health Promotion Directorate, Health and Welfare Canada, Ottawa, Ontario K1A 1B4. Tel. (613) 996-4508*

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GRADE 9 **3.0 Dilemmas and Issues** **Lesson 3.2**

TOPIC	Dating Relationships
STUDENT OBJECTIVES	The student will be able to: 1. recognize the stages in dating, 2. explain how dating is a special way to explore relationships, 3. examine dilemmas in dating relationships.
SUGGESTED STUDENT ACTIVITIES	. Discuss the socialization patterns of adolescents. . Compile a list of characteristics of a successful date. . View a filmstrip on dating relationships. . Discuss questions on relationships.
REQUIRED MATERIALS	. Teacher Background Notes: The Tasks of Adolescents; Adolescent Socialization; Values and Decision-Making . Filmstrip: "Everything But ..." (Guidance Associates)
RESOURCES	1. Manitoba Education. Family Life Education Overview. Winnipeg: The Department, 1985. 2. Lefrancois, Guy R. Of Children: An Introduction to Child Development. 3rd ed. Belmont, CA: Wadsworth Publishing Company, 1980.

DESCRIPTION OF LESSON

I. INTRODUCTION

Introduce this lesson by discussing how dating evolves in several stages beginning with the formation of unisexual cliques; then the formation of mixed girl and boy groups, with individuals being members of more than one group; then, the break up of the groups into couples.

The socialization in groups plays an important part in the dating process. The crowd provides the adolescent with the opportunity to pair off with a partner of the opposite sex within the group. She/he can build up confidence in relating with the opposite sex and still feel the security given by the peer group. Most experts disapprove of going steady at an early age because the socialization needs of the couple will not be met if they miss out on meeting a number of friends.

DESCRIPTION OF LESSON

This lesson explores the leading stages of dating, how to have a successful date, and examines responsibilities of the dating partners.

II. SUGGESTED STUDENT ACTIVITIES

A. Discuss the evolution of dating.

Questions for discussion:

1. At what age did you notice the formation of groups?
2. What were your views of the opposite sex at that time?
3. When did you notice mixed groups being formed?
4. What advantages did these groups have for its members?
5. How will these groups change in the future?

B. Brainstorm how to have a successful date. A date can take many forms, and can be as simple as going to a basketball game. The idea is to have fun and to get to know the other person. Some ideas may include:

- Choose an activity you'll enjoy doing.
- Set the date well ahead of time.
- Tell your parents where you'll be and who you'll be with.
- Arrive on time, or call if you're going to be late.
- Be ready on time. Don't keep your date waiting.
- Don't cancel because you've heard about something more interesting to do instead.
- Don't monopolize the whole conversation.
- Ask questions to keep the conversation going.
- Relax and enjoy yourself.
- If the date was fun, let the other person know.

C. View the filmstrip, "Everything But ..." If time permits, view both Parts I and 2. If not, "Where to Draw the Line" is the topic of Part 2. It deals with the situation described below.

Introduce the filmstrip by pointing out that, as dating progresses the following could happen:

A teenage couple are out on a date. They do a little necking, . . . then what? "Then what" depends on a number of things. It depends partly on such factors as family standards, the values and mores of the community, and the standards of the couple's teenage group. It depends, too, on the couple themselves, on their private standards and feelings, on how much they are aware of and have thought about all that is involved in such a situation.

DESCRIPTION OF LESSON

Because teenagers date at an earlier age than ever before, they face decisions about sex at a time when they have only begun to develop their values and to explore interpersonal relationships seriously. At this time they are establishing their own identity.

Note to teacher - The universal values worksheets will be helpful in the discussion.

Questions for discussion:

1. Do you think some teenage couples are really just "kidding themselves" when they claim to be in love? Why is it difficult to know whether you're really in love?
2. "Whether love makes it right" is the question raised in Part I. Do teenagers confuse love with infatuation?
3. How much of the responsibility for drawing the line do you think the girl should have?
4. How much of the responsibility for drawing the line do you think the boy should have?
5. Identify some factors that suggest premarital abstinence is desirable.
6. What are other sources of information that give conflicting information about the desirability of abstinence (rock videos, rock groups, advertising, etc.)?

III. SUMMARY

Dating usually evolves from a pattern of socialization, beginning with the formation of groups and then of couples. Dating provides an excellent way of having fun and an opportunity to get to know another person of the opposite sex. Dating steadily requires careful thought by the adolescent. While the benefits of a close relationship may be many, there are many undesirable consequences if sexual involvement begins in adolescence.

TEACHER BACKGROUND NOTES: THE TASKS OF ADOLESCENTS

Students need to understand that adolescence is a time of change, a period during which they will become more independent of their families. This means learning how to take charge of one's own life, to become responsible for one's opinions, feelings, moral judgements, and decisions. They will begin to develop their own philosophy of life as well as gain a perspective of the world and their place in it.

The adolescent is faced with accepting, choosing or discovering a new identity and doing so with as much self-esteem as possible. Self-esteem is of fundamental importance to a person's behavior and happiness. It is a personal judgement that indicates the extent to which an individual believes himself/herself to be capable, significant, successful, and worthy.

Different pressures act upon adolescents as they try to become independent. Adults expect them to be responsible for their own decisions and behavior and to be less dependent on them. The adolescents experience inner conflicts. Now looking more and more like an adult, they identify with the independence of adults and want to become more like them. Yet they soon find out that there are pressures acting against the acquisition of this "independence."

Both adolescents and parents are ambivalent about the amount of freedom the adolescent should have. Often the adolescent doesn't know whether to act like a child or an adult, so on occasion, she/he will activate the first then demand to be treated like the second. One day the parents will treat the adolescent like a child, then the next day expect her/him to act like an adult. Both parents and adolescents need to understand that this is part of the "period of change" and that it takes time.

Conflicts between parents and adolescents arise mostly from the adolescent's desire for more freedom in matters concerning spending money, use the family car, how late to stay out, school marks and the choice of clothes, friends and career. Another area of conflict stems from the adolescent persisting in behaving like a child: noise level, disorder, teasing other children, procrastinating, and not doing her/his domestic chores.

Adults should respect the growing maturity of adolescents, as well as their need for independence. Adults should decide what limits are reasonable given the age of the adolescent and stick to them. Even though it may appear differently, adolescents need guidelines and limits. They still need to know they are being cared for as well as being granted more independence.

Independence does not mean that the children break all bonds with their families and become faithful followers of their peer groups. It simply means that they have achieved an independence that will allow them to function in the peer group which is profoundly important in the socialization of the adolescent.

Some of the developmental tasks of adolescence identified in the Overview include:

- achieving new and more mature relations with peers of both sexes
- achieving a social role
- accepting one's physical changes
- achieving a feminine or masculine social role
- achieving emotional independence from parents and other adults
- desiring and achieving socially responsible behavior
- preparing for economic independence
- preparing for marriage and family living
- acquiring a set of values

TEACHER BACKGROUND NOTES: ADOLESCENT SOCIALIZATION

Shortly after the onset of adolescence, children begin to move toward independence. In the early adolescent stage, the parents continue to be of considerable importance, socially, emotionally, and physically. They are still dependent on their family for the physical comforts and the psychological support it provides. It is clear, however, that these adolescents are not as dependent as they were in earlier periods of development.

As they move towards independence, friends take on more importance. This stage of socialization may be a period of conflict for both the parents and the children. Children may find themselves faced by two things: on the one hand there is a fidelity and love for their parents, and their economic dependence on them; on the other hand there is a new found fidelity to friends and a need to be accepted by peers.

The peer groups go through developmental stages, (1) the "unisexual cliques" make up the first two stages, (2) the "crowd" goes through the third and fourth stages, and finally the crowds break up into (3) "couples." Adolescents may find themselves belonging to several groups at the same time.

1. The Cliques

   In early adolescence, the peer groups consist of isolated, single sex cliques. There is very little, if any, interaction between the boy-group and the girl-group. These groups vary in size from two or three to four individuals. They usually share the same interests, concerns, insecurities, etc.

   The clique is very important in the socialization process of the young adolescent. It gives her/him the opportunity to identify with her/his own sex.

2. The Group

   During middle adolescence a new clique system evolves. Groups become heterosexual, members having established a significant relationship with members of the opposite sex. This stage is known as the "crowd" when boys and girls "hang out" together.

   The crowd provides the opportunity to pair off with a partner of the opposite sex within the group. This is an important stage in the adolescent's socialization. She/he can build up confidence in relating with the opposite sex and still have the security that the peer group offers.

3. The Couple

   In the late adolescent stage, there is a gradual disintegration of the groups. Boys and girls begin pairing off into couples.

RESOURCE:

Lefrancois, Guy R. Of Children: An Introduction to Child Development. 3rd edition. Belmont, CA: Wadsworth Publishing Company, 1980.

TEACHER BACKGROUND NOTES: VALUES AND DECISION-MAKING

There are 'right' and 'wrong' values depending on an individual's and a society's religious beliefs, personal beliefs and cultural mores. However, there exists a set of universal or core principles of morality. Over time, civilizations have held eight universal or objective values in common. They include:

1. The Law of General Beneficience - showing kindness and good will to others
2. The Law of Special Beneficience - showing kindness and good will to family and friends
3. Duties to Parents, Elders and Ancestors - showing respect for parents and elders
4. Duties to Children and Posterity - showing respect and reverence for children, who will become our future generations
5. The Law of Justice - showing honesty, sexual justice and equal justice to all
6. The Law of Good Faith and Veracity - having faith and trust in mankind
7. The Law of Good Mercy - having mercy on all those who are in need
8. The Law of Magnanimity - overlooking injury or insult; not hurting or exploiting others either directly or indirectly

Such universal values or core moral precepts, transcend cultural and religious differences. Universal values are supported by the mandate of the school system which states "While it is impossible to identify a particular position on a given set of values that should be conveyed to all, many qualities of mind and character are clearly seen as desirable and should be developed, e.g., honesty, respect and concern for others, empathy and tolerance, cooperativeness, resourcefulness, self-reliance, open mindedness, concern for societal issues and an open attitude towards social change, respect for legitimately constituted authority, capacity for hard work, willingness to become involved in genuine search for solutions to problems." Thus values in health education should focus on a sense of caring and respect for family and others, kindness, honesty, compassion and respect for self.

REFERENCES:

1. Gow, Kathleen. Yes, Virginia, There Is Right and Wrong. Values Education Survival Kit. Toronto: John Wiley, 1980.

2. Manitoba Department of Education. Administrative Handbook. Winnipeg: The Department, 1983. Section 3, p. 3.

TOPIC	Sex-Role Stereotyping
STUDENT OBJECTIVES	The student will be able to: 1. recognize male and female sex-role stereotyping, 2. describe male and female capabilities for a variety of activities, jobs, and careers, 3. recognize the importance of respect and the role of equality in relationships with members of the opposite sex.
SUGGESTED STUDENT ACTIVITIES	. Categorize a list of activities, careers or jobs of interest to adolescents that relate to their own capabilities. . Explain that males and females have equal capabilities for a variety of activities, careers and jobs. . Answer questions about sex roles.
REQUIRED MATERIALS	None.
RESOURCES	1. Thomas, Marlo. Free To Be You and Me. New York: McGraw-Hill, 1974.

DESCRIPTION OF LESSON

I. INTRODUCTION

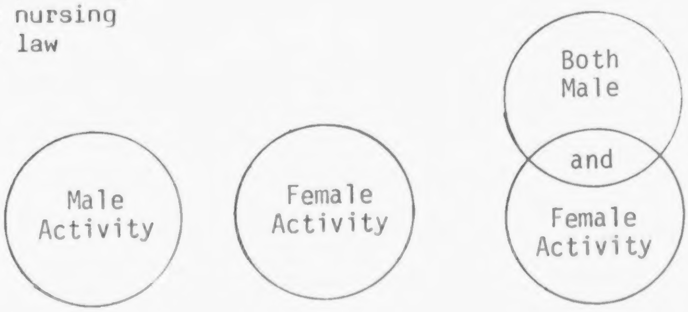
Brainstorm a list of activities (social, recreational and/or cultural), careers and jobs that are of interest to boys and girls, and record them on the blackboard. Ask students to examine the list and think about the activities, jobs and careers that can be done by males, females, or both males and females.

II. SUGGESTED STUDENT ACTIVITIES

A. Divide the class into groups of four to six with an equal number of boys and girls, and ask them to examine four or five activities (jobs and careers). A sample diagram for discussion purposes may be used. Ask groups to think about and discuss why they think both males and females can do the activity or if only males or females have capabilities to do what they would like to do.

Example:

- work at a fast food restaurant
- auto repair
- child rearing
- babysitting
- teaching
- plumbing
- nursing
- law



B. Questions to pose on follow-up can include:

1. Is it necessary to be either male or female to do some/all jobs?
2. Why do you think there are few male nurses, male kindergarten teachers, female principals, female firefighters?
3. What are your career aspirations?
4. What leisure activities do you like? What reasons do you have for that choice?
5. How can boys and girls promote respect and strive for equality with each other?

III. SUMMARY

Review the idea that males and females have capabilities for a variety of activities, careers and jobs.

Stress that it is equally important for males and females to pursue career pathways. Today's society encourages personal growth for males and females throughout life.

Males and females who make choices based on interest, enjoyment and capabilities earn respect and acquire equality.

TOPIC

Making Responsible Sexual Decisions: Abstinence

STUDENT OBJECTIVES

The student will be able to:

1. identify examples of pressures that influence sexual behavior decisions,
2. recognize why abstinence is the best choice for adolescents,
3. recognize the importance of making responsible decisions about sexual behavior.

SUGGESTED STUDENT ACTIVITIES

- Prepare a list of reasons for and against adolescent sexual involvement.
- Discuss unexpected consequences of premarital sex.
- Discuss a variety of pressures that have an impact on adolescent sexual decision making.
- Defend abstinence as a viable choice for young people.

REQUIRED MATERIALS

- Teacher Background Notes: Sexual Involvement: For, Against, Unexpected Consequences; Pressures; Fact Sheet

RESOURCES

1. Film: "Running My Way"
2. "Postponing Sexual Involvement" (for Teens); (for Parents) (kit), Emory-Grady Teen Service Program, Grady Memorial Hospital, Atlanta, GA.
3. Herold, E. S. Sexual Behavior of Canadian Young People. Markham, ON: Fitzhenry and Whiteside, 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

This lesson incorporates a given value, and that value is that young people should not become sexually involved.

Since the late 1960s, researchers have begun to report significant increases in the rates of premarital intercourse, particularly among women. In a study of girls aged 15-19 (1971-1976), the percentage of sexually active girls increased from 15-18% for 15-year-olds and from 47-55% among 19-year-olds. In 1976, the average age of first intercourse dropped from 16.5 to 16.2 (Zelnek and Kantner, 1977).

DESCRIPTION OF LESSON

Canadian studies indicate that a significant proportion of older adolescents are having sexual intercourse, but they also show that most younger adolescents are not. Canadian attitudes toward sexual behavior have changed when viewed today as compared to the early 1960s when most youth believed intercourse was not acceptable until one was married or, at least, engaged.

Today, many young people are confused about sexual behavior standards because of the mixed messages in their environment.

There are four discernible viewpoints on societal attitudes toward sexuality. They are:

1. Abstinence. Sexual intercourse before marriage is wrong for both males and females and should be reserved for marriage.

2. Double Standard. Sexual intercourse before marriage is acceptable for males but not for females; virginity is prized for females.

3. Permissiveness in a love relationship. Sexual relations between unmarried people are acceptable as long as partners feel a strong affection for each other and their relationship is a strong one. No marriage commitment is required.

4. Permissiveness without affection. Casual sexual relationships between consenting people are acceptable; physical attraction, sexual desire is emphasized. (Ira Reiss on Current Health Problems, 1979.)

Many adults view society's changing attitudes toward sexual behavior and the trend toward permissiveness with alarm and believe that changing moral standards will lead to social demise. Other adults accept the trend. The influences subtly sway attitudes of the contemporary world. These two attitudes and those that fall between subtly influence adolescent behavior and contribute to a climate of confusion.

The family, church and community need to stress that abstinence from intercourse is a viable option and that teenagers should not feel pressured into sex. About 50% of Canadian teenagers have not experienced intercourse by the age of nineteen. This group and that composed of younger teenagers need support for their decision to abstain. (Herold, 1984.)

As each teenager prepares for adulthood, each must come to grips with many important life decisions. One such decision, and a major one at that, that must be made is whether one is going to engage in premarital sex or to abstain from it. This decision is a personal decision based on family values and religious beliefs. Decisions about sexual involvement are difficult in the face of environmental and societal pressures which exert persuasive influence. Being able to take charge of a major life decision and be responsible for it not only provides a standard to counteract pressures but brings about personal satisfaction.

II. SUGGESTED STUDENT ACTIVITIES

A. Divide the class into small groups. Ask students to:

1. Make a list of reasons that young people give for becoming sexually involved.
2. Make a list of reasons that young people give for postponing sexual involvement.

Then discuss with the class the unexpected consequences of premarital sex and list these on the blackboard.

Refer to Teacher Background Notes: Sexual Involvement: For, Against, Consequences.

B. Define sexual abstinence as the choice, made by both males and females, to avoid sexual involvement until marriage. Discuss a variety of pressures that have an impact on young people in relation to sexual decision making. See Teacher Background Notes: Pressures and Fact Sheet.

C. Discuss the advantages and disadvantages of abstinence.

Advantages	Disadvantages
. The satisfaction of being in charge of a major life decision.	. Teasing or rejection by some peers or friends.
. Freedom from worry about violating personal, family and religious beliefs and values.	. Pressure to justify standard.
. Freedom from concern about contracting a sexually transmitted disease or getting pregnant.	

- Enhancement of self- worth and health because feelings of self-esteem and reputation are maintained.
- Satisfaction of knowing that abstinence is an accepted standard practices by most teens.
- Development of assertiveness to deal with pressure about chosen standard.
- Freedom from worry about unexpected health consequences (social, emotional, physical, intellectual, spiritual).
- Increased time to pursue leisure, career, school and recreation goals.
- Strengthening of a dating relationship built on trust and respect rather than sex.

III. SUMMARY

Sexual abstinence is the only 100% effective method of preventing pregnancy. Young people should be encouraged to abstain from sexual involvement and should be able to defend their choice by referring to a standard based on their family's values or on universal values. Having such a standard gives teens a feeling of taking charge of a major personal decision. Adolescents need the support of their families, their church and other community agencies not only to set such a standard but to abide by it.

TEACHER BACKGROUND NOTES: SEXUAL INVOLVEMENT: FOR, AGAINST, UNEXPECTED CONSEQUENCES

Reasons Why Some Teens Become Sexually Involved

- pressure from boyfriend/girlfriend, desire to maintain a dating relationship
- permissiveness of society
- rebellion against parents, teachers, and authority figures to show independence
- expression of love
- curiosity
- desire to impress the peer group
- physical pleasure or fun
- expressing the strength of sexual drive
- mutual desire
- desire to appear macho or liberated
- desire to receive welfare money as a single parent
- force and fear
- rape, incest

Reasons Why Some Teens Postpone Sexual Involvement

- moral objections
- unreadiness for premarital sex
- absence of the right person
- fear of parent disapproval
- fear of pregnancy
- unreadiness of partner to engage in premarital sex
- fear of damage to potential for personal growth and other opportunities
- development of wider interests in dating relationships
- fear of change in reputation
- fear of discussion of sexual activity by partners
- fear of risk of sexually transmitted diseases (cancer of cervix from early sexual activity)
- worry about having to make contraceptive choices
- decision to wait for a committed relationship
- decision to strengthen relationship built on mutual trust and respect
- desire to avoid negative feelings--guilt, fear, shame, disappointment
- desire to avoid risk of having to drop out of school and miss graduation
- desire to avoid any set back to career plans

Consequences of Having Sex - Unexpected Results

- pregnancy
- sexually transmitted disease
- risk of infection and possible sterility
- dropping out of school
- guilt, rejection, loss of self-respect and reputation
- change of relationships with family, friends, boyfriend or girlfriend
- responsibility for parenting a child
- reduction of future health potential--herpes, cancer of cervix as a result of early intercourse
- reduction of health potential of unborn (low birth weight, low IQ, congenital disease, infections)
- difficult birth and medical complications
- changed reputation
- poverty: welfare or limited earning-ability

TEACHER BACKGROUND NOTES: PRESSURES

There are a variety of pressures that have an impact on teens' sexual decision making. Examples are:

1. Peer pressure - the desire to be part of a group, to be popular, or "with it" may prevent an individual from making a personal choice based on his or her own or family values.

2. Entertainment pressure - subtle and not so subtle messages to teenagers to have sex to feel grown up comes from live and recorded music, performing groups, magazines, videos, television programs and movies.

3. Internal pressure - the desire to establish independence from parents sometimes takes the form of challenging or defying family values.

4. Family pressure - families may discourage teens from becoming sexually involved or send out mixed messages of various kinds, for instance, condoning male involvement while condemning female involvement.

5. Churches - churches encourage young people to postpone sexual involvement until marriage.

6. Community pressure - community institutions offer confusing and conflicting messages in the very type of service they provide, so that it is not clear whether they condone sexual involvement or not. Some, for instance, offer birth control methods, abortion, going ahead with pregnancy; others provide counselling, offer placement of babies for adoption and assistance for single parents.

With such a variety of views, some teens may be left confused.

TEACHER BACKGROUND NOTES: FACT SHEET

1. Puberty occurs earlier today than it has in the past. Girls, on the average, begin to menstruate at twelve and a half years and boys begin producing sperm at about thirteen and a half. Once puberty begins, teens are capable of having babies, but are not capable of rearing babies.

2. Pregnancy can result at an early age if intercourse occurs at the time of ovulation--even if it is the first sexual encounter. Pregnancies can occur from heavy petting that doesn't necessarily involve intercourse if sperm is deposited at the entrance of the vagina.

3. Many complications result from premarital sex: pregnancy, sexually transmitted diseases, sterility, cancer, a sense of psychological exploitation, guilt from the violation of family values and attitudes, unsatisfactory future relationships and unhappiness.

4. Being able to develop long-lasting, committed relationships and take full responsibility for personal behavior is different than being able to have sex. Having sex is not the same thing as being grown up.

5. Abstinence is the only 100% effective way of preventing a pregnancy.

6. Teenage pregnancy places independence, self-esteem and self-identity, and health at risk.

7. Sex is not necessarily the same thing as love, nor is it, by itself, the basis for a sound relationship.

GRADE 9 | 3.0 Dilemmas and Issues | Lesson 3.5

TOPIC

Solving Problems Assertively

STUDENT OBJECTIVES

The student will be able to:

1. describe assertive responses that allow one to say "No" to pressure regarding sexual involvement,
2. practice solving problems involving sexual behavior assertively,
3. recognize some points of Canadian law about the sexual abuse of minors,
4. recognize the importance of knowing and using support systems.

SUGGESTED STUDENT ACTIVITIES

- Solve case studies using assertiveness to resist sexual involvement.
- Discuss the importance of utilizing family-friend and community support systems.
- Discuss some points of Canadian law regarding the sexual abuse of minors.

REQUIRED MATERIALS

- Teaching Aids: Case Studies A and B
- Teacher Background Notes: Child Sexual Abuse and Exploitation; Manitoba Guidelines on Identifying and Reporting Child Abuse; Values and Decision-Making

RESOURCES

1. Film: "Saying No"
2. Kit: Postponing Sexual Involvement (for teens; for parents), Emory-Grady Teen Services Program, Grady Memorial Hospital, Atlanta, Georgia.
3. Kit: The Gentle Art of Saying No. Pleasantville, NY: Sunburst Communications, 1979.
4. Botvin, G.J. Life Skills Training. New York: Smithfield Press, 1979.
5. Sexual Offences Against Children in Canada: Summary (The Badgley Report). Ottawa: Supply and Services Canada, 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

This lesson may require two class periods.

DESCRIPTION OF LESSON

Today, adolescents are beginning to date and become involved in steady dating relationships at an earlier age than in the past. For many teens, dating is an important stage in their development that enhances their self-worth, increases their personal happiness, and produces close friendships. Even though dating may be important, many teenagers have difficulty with the complex parameters of dating relationships. Given a variety of pressures from society, adolescents who engage in steady dating relationships are more likely to be pressured into earlier sexual involvement. They may lack awareness of the unexpected consequences of adolescent sexual involvement.

Adolescents need to build a repertoire of basic assertive skills to handle pressure coming from peers. Parents and significant others can support adolescents by helping them recognize problems and understand their right to say "no" to sexual involvement. Parent-friend and community support systems should be recognized and utilized by young people to deal with serious personal problems.

It is suggested that the teacher review principles of assertiveness in the "Social-Emotional Well-Being" unit of the Grade 7 Health curriculum (objectives 2.4 and 2.5) and the Grade 8 Health curriculum (objective 2.1). See also the accompanying Teaching Aids and decision-making model using universal values.

II. SUGGESTED STUDENT ACTIVITIES

A. Teens need to know that a large number of older adolescents do not have sexual intercourse. Herold (1984) states that only 50% of 19-year-olds engage in sexual behavior. Most young teens do not want to be sexually active. They need to know it is their right to "say no" if someone asks them to do something they do not want to do, or know they should not do.

Three useful steps that help in handling pressure are:

Step 1: Say "No" and repeat it.

Step 2: State how the person's pressure makes you feel. Use an "I message" or justify with an assertive reply.

Step 3: Walk away from the problem. Refuse to discuss it further.

The teacher should demonstrate how to apply assertive steps using the following problem:

Kevin and Sue

Kevin, age 16, invited Sue, age 14, to his house to listen to records. They listened to several records and made popcorn together. Kevin begins to pressure Sue "to neck."

How can Sue assert herself so that Kevin is not hurt and Sue is not pressured into necking? (She can say "No" assertively and cite the protection of Canadian law since she is under the age of sixteen.)

B. Divide the class into small groups to discuss one or more case studies from List A.

C. Discuss child sexual abuse and exploitation. Refer to Teacher Background Notes. You may wish to use one or more case studies from List B for problem solving in the large group.

D. Encourage each student to identify, recognize and utilize persons for both:

1. Family-friend support system, and
2. Community support system (e.g., police, firefighters, Block Parents, Child Protection Agencies, doctor, nurse, school authority). Students should know that they have a right to be protected from sexual abuse. Preventive measures include:
    - telling a person from support systems if sexual abuse has occurred
    - telling until the abuse stops.

School teachers should be alert to any request for help and refer the student to the correct authority following authorized procedures. See Manitoba Guidelines on Identifying and Reporting Child Abuse.

III. SUMMARY

Societal pressures and steady dating may contribute to early sexual involvement. Assertiveness skills as well as a knowledge of support systems, Canadian law and the health risks of early involvement provide students with a basis for making wise decisions.

CASE STUDIES A: DATING DILEMMAS

1. Sandy is a ninth grader who has just started dating Dan, a grade 11 student. Sandy is very excited about the attention she receives from Dan. He plays basketball, has a job at the local store, and owns a car. One evening as they were visiting with a friend at the local hangout, Dan invited Sandy to his place to watch a video movie. It would be just the two of them because his parents were out for the evening.

    1. What concerns might Sandy have?
    2. What are her alternatives/consequences?
    3. What should Sandy do?
    4. What values might or might not be at issue?

2. Cameron and Kathy have dated for several months. Cameron has taken Kathy out for pizza and several shows. Kathy has enjoyed all of the attention and is excited to have a boyfriend.

    Cameron begins to talk to Kathy about several of his friends who are having sex with their girlfriends. Cameron is curious about having sex and begins to pressure Kathy.

    1. What concerns might Kathy have?
    2. What are her alternatives/consequences?
    3. What should Kathy do?
    4. What values might or might not be at issue?

3. Janet and Bill have been dating for several weeks. They really enjoy each other's company. Janet considers herself mature. To prove to her friends that she and her boyfriend are "with it," she encourages her boyfriend to stay out late and neck heavily. Bill feels embarrassed that Janet has made a hickie on his neck.

    1. What concerns might Bill have?
    2. What are his alternatives/consequences?
    3. What should Bill do?
    4. What values might or might not be at issue?

4. Teena and Steve were part of a large group of grade 9 friends that went to movies together, saw videos together at someone's home, and frequently snacked at the local fast-foods restaurant. Teena enjoyed the groups' activities and had no special interest in any one of the boys. Steve began to pressure Teena to go steady.

   1. What concerns might Teena have?
   2. What are her alternatives/consequences?
   3. What should Teena do?
   4. What values might or might not be at issue?

NOTE: In handling each case study, the teacher should encourage students to make their decisions congruent with their family's or with the universal values.

CASE STUDIES B: UNACCEPTABLE SEXUAL BEHAVIOR

These are actual cases as reported in Sexual Offences Against Children, Volume I, The Badgley Report, 1984.

1. 20 year-old college student, Vol. I, p. 166. When she was 15, a 16 year-old boyfriend exposed himself. On another occasion, he threatened to have intercourse with her. Subsequently, he attempted to rape her. "He tried to force to make love with me. He made fun of me because I'd be old and a virgin." She told her sister about what happened. "I could have been helped better if I would have been more informed about sex, its outcomes (physically and emotionally). Perhaps if they taught it in school about Grade 7."

2. 43 year-old mother of 3 children, Vol. I, p. 266. Between the time she was 11- and 12-years-old, she was initially exposed to. She was subsequently threatened with having intercourse and then raped by "a man who worked on our family farm." She told no one about this. This woman recommended "Better sex education at school and by parents; and better supervision by adults of children's activities."

3. 44 year-old salesman, Vol. I, p. 191. When he was about four years old, he was "sexually molested by a baby sitter, an 18-year-old female. As a small child, this left a bad memory. "Keep care of your kids yourself. Don't farm them out to others."

4. 21 year-old student, Vol. I, p. 190. When she was 13 her breasts and crotch were grabbed by her 15-year-old date who threatened to have sex with her. "My boyfriend had several bottles of beer. His friend encouraged him to try drugs. Everyone was experimenting with sex so I felt it was a normal reaction for him." She told no one about the incident.

5. 43 year-old planner, Vol. I, p. 191. When he was 16, he had been "approached in a public washroom by a homosexual" who fondled his penis. "I should have reported the incident to the police to prevent other assaults to persons."

6. 40 year-old clerk, Vol. I, p. 190. When she was 8, her step-father regularly had intercourse with her. She subsequently had a child. Because she was afraid, "the family kept it very quiet. I feel mothers should be at home with their children, instead of working or running around."

7. 30 year-old manager, Vol. I, p. 192. When she was 10, a 16-year-old cousin attempted to rape her. "My cousin told me we were playing a game." She told no one about the incident.

TEACHER BACKGROUND NOTES: CHILD SEXUAL ABUSE AND EXPLOITATION

Child sexual abuse is only one of many problems facing Canadians. Few victims of sexual offences seek assistance from the helping services. Many victims have been scarred for life with uncertainty, fear and despair.

Historically, Canadian law has failed to recognize the complexity of child sexual abuse and the many forms unacceptable sexual behavior takes.

The Badgely Report, 1984, has made numerous recommendations to clarify sentencing policy, reform existing laws and restructure services to afford better protection and assistance for children and youth regarding sexual abuse and exploitation.

The following points from the Badgely report illustrates findings from the committee's research.

- At sometime during their lives, about one in two females and one in three males have been victims of one or more unwanted sexual acts. These acts include: being exposed to; being sexually threatened; being touched on a sexual part of the body; and being sexually assaulted or the victim of an attempted assault.
- About four in five of these unwanted sexual acts had been first committed against these persons when they were children or youths.
- Four in 100 of young females have been raped.
- Two in 100 of young persons have experienced attempts or actual acts of unwanted anal penetration by a penis, objects or fingers.
- Acts of exposure constitute the largest single category of sexual offences committed against children. Cases were documented where such acts were followed by sexual assault.
- Three in five sexually abused children had been threatened or physically coerced by their assailants. Young victims are as likely to be threatened or forced to engage in sexual acts by persons relatively close in age as by older persons.
- Few young victims were physically injured; substantially more suffered emotional harm.
- About one in four assailants is a family member or a person in a position of trust; about half are friends or acquaintances; and about one in six is a stranger.
- Virtually all assailants are males; one in 100 is a female.
- A majority of victims or their families do not seek assistance from public services. When they do, they turn most often to the police and doctors.

- Over two in five of all sexual assault homicides are committed against children age 15 and younger. Children are victims of three out of four convicted sexual offenders found to be dangerous on sentencing by courts.

Source: The Badgely Report, pp. 1, 2.

It is important for teens to be aware of Canadian laws about unacceptable sexual behavior and to be better informed about the prevention of sexual abuse and exploitation.

- If young people go beyond normal adolescent "petting," any given consent does not apply when a girl is under the age of 16 and anal or genital sex is involved.

- Under current Canadian law, there is an absolute prohibition against any male having sexual intercourse with a female who is under 14 years and who is not his wife. An accused found guilty of the offence is liable to imprisonment for life. Consensual intercourse involving girls 14 or 15 is prohibited in a qualified form. The court may find the accused not guilty if the evidence does not show that the accused was more to blame than the female for sexual behavior.

- Under current Canadian law, two persons must be 21 or older to be assured that none of their private consensual sexual conduct constitutes a criminal offence. Incest represents an exception to this rule.

- Gross indecency and buggery (anal sex) with another person are prohibited for both boys and girls up to age 21.

Source: Summary, The Badgely Report, pp. 18-21.

Manitoba Guidelines on Identifying and Reporting Child Abuse

Child abuse is a grave, growing and often self-perpetuating problem, which knows no social barriers. Violence in the family is often physically and always emotionally devastating, not only to the child but to the entire family.

Its identification, treatment and prevention require the close collaboration of child caring agencies, law enforcement units, health care workers, educators, and all whose concerns, whether professional or non-professional, touch upon and affect the lives of children.

Expressing a strong commitment to assisting in the provision of a speedy, effective and broad range of services to children and families at risk, the Ministers of Community Services, Health, Education and the Attorney General jointly issue these Guidelines on Child Abuse. Their purpose is to provide a procedural and legal framework for the investigation, detection and management of child abuse cases to the growing community of professionals and lay persons providing services to children and their families.

Definitions:

The following definitions apply for the purpose of these guidelines, which are primarily intended for child abuse within the family:

1. "Abuse" means an act or omission by the parent or person in charge of the child, which act or omission results in harm to the child. It includes, but is not necessarily restricted to: physical beating, sexual abuse, and failure to provide reasonable protection for the child from physical harm.

2. "Sexual abuse" means any exploitation of a child whether consensual or not for the sexual gratification of a parent or person in charge of a child and includes, but is not necessarily restricted to: sexual molestation, sexual assault, and the exploitation of the child for purposes of pornography or prostitution.

   Sexual abuse includes "incest". Incest is a crime under the Criminal Code of Canada. Therefore the involvement and participation of the local police force is essential in all incest investigations.

   Sexual activity between children may constitute sexual abuse if the differences in ages between the children is so significant that the older is clearly taking sexual advantage of the younger.

3. "Emotional abuse" means acts or omissions on the part of the parent or the person in charge of a child, which acts or omissions include but are not restricted to:

   (a) any unwillingness or inability to provide appropriate care, control, affection or stimulation for a child;

   (b) making inappropriate demands upon a child;

   (c) exposing a child to frequent family violence tending to produce permanent or long-term emotional disability, including:
      i. non-organic failure to thrive;
      ii. developmental retardation;
      iii. serious anxiety, depression or withdrawal;
      iv. serious behavioural disturbances.

   Emotional abuse remains a major concern but does not require police intervention. Nevertheless, a multidisciplinary team approach may be essential in certain emotional abuse cases.

4. "A person in charge of a child" means a person responsible for a child's welfare and includes a guardian or person within the context of a family relationship or foster parent.

5. "Third party assault" means abuse which occurs outside the family and technically does not fall within the guidelines but, nevertheless, is subject to:

   (a) police investigation,

   (b) referral to an appropriate agency for service, and

   (c) reporting of the incident to the central abuse registry.

6. "Child" means a person under the age of majority. (In Manitoba the age of majority is eighteen).

7. "Child caring agency" means:
   i. a children's aid society, or
   ii. a regional office of the Department of Community Services, or
   iii. a child welfare committee appointed under Section 7 of the Child Welfare Act.

Manitoba

8. "Medical child abuse unit" means professionals within a hospital setting who are specifically responsible for handling suspected or alleged child abuse cases.

   It is expected that the management of child abuse cases within a hospital setting will be from an interdisciplinary perspective and that a hospital child abuse team will therefore be a member of the regional or community team/committee which includes the local child caring agency, law enforcement and medical/health personnel.

2. (a) Where a report of suspected or alleged child abuse is received by a child caring agency, the agency will consult immediately with the local police force;

   (b) Where a report of suspected or alleged child abuse is received by the local police force, the police will consult immediately with the appropriate child caring agency;

   (c) Where a report of suspected or alleged child abuse is received by a hospital or other medical health centre with a recognized medical child abuse unit, the hospital/centre will report the incident to the appropriate child caring agency and local police force immediately; and

   (d) Where a report of suspected or alleged child abuse is received by a hospital or medical health centre without a recognized medical child abuse unit, the hospital/centre will immediately report the incident to the appropriate child caring agency, the local police force or the nearest recognized medical child abuse centre.

3. To ensure that the best course of action is taken in every case, there shall be a mutual sharing of all relevant information by the agencies and professionals involved in the investigation and treatment process.

4. The protection of the child is the responsibility of all persons involved. The child caring agency, however, has the mandate to protect the child as provided for in the Child Welfare Act (Manitoba), with guidance from the professional team members where a recognized medical child abuse unit exists.

5. Every child caring agency which receives information about the suspected or alleged abuse of a child, including a child in the care of the agency, shall report the information to the Director of Child and Family Services, as required by the Child Welfare Act (Manitoba) in the manner and form set out in the regulations.

   Notwithstanding the mandatory requirement for a child caring agency to report, any other professional may and should report a child abuse incident in the same manner and form to the Director of Child and Family Services.

6. The office of the Director of Child and Family Services shall issue statistical and descriptive data, as extracted from agency reports of suspected or alleged child abuse. A regular review of all abused children reported to the Director shall be required in the manner and form set out by the Director, to ensure the sound disposition of each case, the continuity of service and ultimately the safety of all abused children or children at risk anywhere in the Province.

7. Each child caring agency should inform the reporter of suspected or alleged abuse of action taken on the report at the earliest appropriate time.

8. In all cases of physical and sexual abuse the Crown Attorney shall determine the appropriateness of laying any charges upon completion of the preliminary investigation by the child abuse team.

   In circumstances where the seriousness and urgency of the case dictates, charges will be laid without prior consultation. It is expected, however, that subsequently there will be ongoing consultation from the initial reporting to the final disposition.

It is our hope that this multidisciplinary team approach will ensure that the needs of abused children are met, that their rights are protected and that, wherever possible, families can be kept together with the continued support of all involved.

DATED at the City of Winnipeg, in the Province of Manitoba, this 13th day of April, 1984.

Muriel Smith

Minister of Community Services
and Corrections

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TEACHER BACKGROUND NOTES: VALUES AND DECISION-MAKING

There are 'right' and 'wrong' values depending on an individual's and a society's religious beliefs, personal beliefs and cultural mores. However, there exists a set of universal or core principles of morality. Over time, civilizations have held eight universal or objective values in common. They include:

1. The Law of General Beneficience - showing kindness and good will to others
2. The Law of Special Beneficience - showing kindness and good will to family and friends
3. Duties to Parents, Elders and Ancestors - showing respect for parents and elders
4. Duties to Children and Posterity - showing respect and reverence for children, who will become our future generations
5. The Law of Justice - showing honesty, sexual justice and equal justice to all
6. The Law of Good Faith and Veracity - having faith and trust in mankind
7. The Law of Good Mercy - having mercy on all those who are in need
8. The Law of Magnanimity - overlooking injury or insult; not hurting or exploiting others either directly or indirectly

Such universal values or core moral precepts, transcend cultural and religious differences. Universal values are supported by the mandate of the school system which states "While it is impossible to identify a particular position on a given set of values that should be conveyed to all, many qualities of mind and character are clearly seen as desirable and should be developed, e.g., honesty, respect and concern for others, empathy and tolerance, cooperativeness, resourcefulness, self-reliance, open mindedness, concern for societal issues and an open attitude towards social change, respect for legitimately constituted authority, capacity for hard work, willingness to become involved in genuine search for solutions to problems." Thus values in health education should focus on a sense of caring and respect for family and others, kindness, honesty, compassion and respect for self.

REFERENCES:

1. Gow, Kathleen. Yes, Virginia, There Is Right and Wrong. Values Education Survival Kit. Toronto: John Wiley, 1980.

2. Manitoba Department of Education. Administrative Handbook. Winnipeg: The Department, 1983. Section 3, p. 3.

TOPIC

Teenage Pregnancy: Risks, Consequences, and Prevention

STUDENT OBJECTIVES

The student will be able to:

1. examine pregnancy trends among Canadian youth,
2. recognize the risks and consequences of teenage pregnancy to maternal and child health,
3. describe methods to prevent teenage pregnancy,
4. identify sources of information for adolescents on pregnancy prevention.

SUGGESTED STUDENT ACTIVITIES

- Participate in a lecture and discussion about teenage pregnancy, its consequences and prevention.
- Describe local sources of information for pregnancy prevention.

REQUIRED MATERIALS

- Teacher Background Notes: Teenage Pregnancy Trends and Consequences; Contraceptive Methods Relevant to Young People

RESOURCES

1. Public health nurse, medical doctor
2. Herold, Edward. Sexual Behavior of Canadian Young People. Markham, ON: Fitzhenry and Whiteside, 1984.
3. Kane, Wm., ed. Healthy Living: An Active Approach to Wellness. Indianapolis: Bobbs-Merrill Educational Pub., 1985.

DESCRIPTION OF LESSON

I. INTRODUCTION

Two classes will be required if a film is used to support the lesson.

This lesson reviews a given value: young people should not become sexually involved. For the adolescent who may be sexually active and/or uninformed, information is provided about pregnancy prevention including abstinence and other contraceptive methods.

DESCRIPTION OF LESSON

II. SUGGESTED STUDENT ACTIVITIES

A. Describe and discuss with students Canadian trends of teenage pregnancy. Refer to Teacher Background Notes: Trends.

B. Discuss consequences of teenage pregnancy on maternal and fetal health.

C. Discuss pregnancy alternatives.

Most young people do not plan to have sexual intercourse; hence, they do not plan to use contraceptives. Before a girl is willing to use contraceptives, she must believe that engaging in intercourse is a possibility and that a pregnancy may occur (Herold, 1984). Stress that pregnancy is a natural outcome of sexual intercourse unless prevention is used consistently. Responsibility for such prevention should be shared by the male partner in sexual intercourse, mainly by the appropriate use of condoms.

Invite a public health nurse or medical doctor to the class to provide straight-forward information on:

1. sexual abstinence
2. methods of conception control for males and females
    - . advantages and disadvantages
    - . problems and considerations
    - . sources of information on conception control

Note: Abortion is not a method of conception control.

Sources of information for adolescents on conception control are: medical doctors, public health nurses, community clinics, parents. Students should know about local community services, their policies about confidentiality, required examinations and follow-up medical supervision.

III. SUMMARY

Teenagers today need to make personal decisions about sexual involvement. These decisions should be based on their families' values or the universal values and current information about sexual involvement. Unplanned pregnancies precipitate serious consequences to mother, child and significant others. Teens should be encouraged to abstain from intercourse. Those, however, who are sexually active already and intend to remain active should know that pregnancy prevention involves the consistent use of appropriate contraceptives approved by health professionals and agencies, and significant others.

TEACHER BACKGROUND NOTES: TEENAGE PREGNANCY TRENDS AND CONSEQUENCES

Adolescent Trends

- the teenage population in Canada is decreasing at the present time--over 8% decrease in the last 10 years.
- live births to 12-17 year olds declined from 42,574 in 1970 to 31,273 in 1980.
- birth rates for 15-17 year olds declined by 30% from 1970 to 1980.
- birth rates for 18-19 year olds declines by 39% from 1970 to 1980.
- birth rates for 10-14 year olds did not change.
- some part of the reason for these declines is due to increased use of contraceptives and the increased availability of abortions.
- contraceptives are being used by 9% of 15-17 year olds and by 29% of 18-19 year old females, but many of this age group who are sexually active do not use any contraceptive measures.

Abortions

- in Manitoba during 1982, there were 1,728 abortions performed and 30% of these were in women aged 15-19.
- in addition, a large number of Manitoba residents had abortions in private clinics in the United States.
- 25% of teenagers having abortions are more than 12 weeks pregnant and therefore at high risk for complications.

Motherhood

- in 1971, 30% of adolescent mothers kept their babies compared to 85% in 1981.
- lone-parent families headed by a female aged 15-24 increased 97% between 1971 and 1981.

Consequences of Pregnancy for the Teen Mother

- the teen mother is usually forced to drop out of school; her limited educational resources place a severe limit to type of joys (unskilled or semi-skilled) available to her.
- she may feel compelled to marry.
- her limited financial resources usually compell her to seek welfare or government financial aid.
- she is forced to choose poor accommodations and moves frequently.
- she has to deal with psychological effect of such parenthood--loneliness, isolation, low self-esteem.
- she may receive help with baby care, finances, and emotional support, if she is from a family in the higher socio-economic brackets.
- she may suffer any of a number of complications of teenage pregnancy including: poor diet, inadequate and late pre-natal care, emotional stress, and numerous medical risks (postpartum hemorrhage, hypertension,

pelvic inflammatory disease, toxemia, anemia, premature labor, lack of pelvic capacity, prolonged labor, placenta problems.
- she may suffer from fatigue resulting from an iron deficient diet.
- she may have frequent vaginal infections.
- her own physical growth is taxed.

Consequences of Teenage Pregnancy for the Child

Children born to teenage mothers often suffer from the following:

- low birth-weight.
- higher rate of infant mortality, deformities and failure to thrive.
- lower intellectual potential.
- various effects as a result of drug use during pregnancy; e.g., smoking lowers birth weight and may cause premature babies; alcohol may induce fetal alcohol syndrome--characterized by malformed facial features, growth failure, mental retardation, poor coordination.
- increased childhood diseases.
- lower education aspirations when a teenager.
- less intellectual encouragement.
- decreased stimulation for development.
- decreased likelihood of achieving a good life.
- increased risk of child abuse.

In summary, adolescent mothers are at a disadvantage. Most have incomplete education and limited financial and emotional support. Without support systems, many mothers struggle to survive and maintain their own well being in many of the dimensions of life--physical, emotional, social, spiritual and economic. These young women need assistance from a variety of sources including community health and social service agencies. They also need parenting programs and peer group assistance to help improve their conception of themselves.

REFERENCES:

1. "Adolescents Face Stressful Life Changes." Vol. 22, no. 2.

2. Therapeutic Abortion Annual, Stats Canada 1982, Table 30, p. 73.

TEACHER BACKGROUND NOTES: CONTRACEPTIVE METHODS RELEVANT TO YOUNG PEOPLE

The worry of becoming pregnant or causing pregnancy is a major cause of stress among young people. Most sexually active adolescents wish to avoid pregnancy and want to be sexually responsible in using contraception. Both males and females must accept the risk that sexual activity involves (pregnancy, STDs), and both should take responsibility for using effective contraception consistently. This means that males must assume increasing responsibility for contraception.

Herold (1984) notes that, although most teens view pregnancy as a highly stressful life event and wish to avoid it, they also have difficulty planning contraception because:

- intercourse is sporadic and unplanned;
- guilt accompanies the thought of contraceptive planning;
- obtaining and using contraceptives causes embarrassment; and
- confidentiality about obtaining and using contraception is a major concern.

Young people who plan to use effective contraception prior to their first intercourse are in the minority. Tending to rely at first on such an undependable method as withdrawal, they wait for long periods without seeking more effective protection. Only if they understand that pregnancy is a definite risk will they seek more effective methods. Teenage pregnancy statistics indicate, however, the difficulty they have in accepting the reality of this risk.

Consistent use of effective contraception is a mutual responsibility of sexually active males and females. They should both be prepared to accept the consequences if contraception fails and pregnancy results. Described below are various methods of contraception as well as their advantages and disadvantages.

1. Sexual abstinence is the only 100% effective method of preventing pregnancy. Young people should be encouraged to refrain from becoming sexually involved. Abstinence is a viable option, and teenagers should be discouraged from and not be pressured into sexual encounters.

   Effectiveness - 100%

   ### Advantages

   - satisfaction of taking charge of a major life decision
   - freedom from worry about violation of morals
   - more time to pursue leisure, career, school and recreation choices
   - freedom from worry about health consequences
   - freedom from worry about pregnancy
   - freedom from worry about sexually transmitted diseases
   - health and self-worth are enhanced
   - self-assertiveness to justify standards or deal with pressures
   - abstinence is a viable and accepted standard by most teens

Disadvantages

- teasing or rejection by peers or friends
- pressure to justify reasons for abstinence

2. Oral Contraceptives

The pill is the most popular method of birth control among young people.

Combination pill--tablets consisting of estrogen and synthetic progestin that suppress ovulation. Various combinations are available but all of them prevent pregnancy by suppressing ovulation.

Not all women can use the pill. There are absolute contraindications to pill use.

Advantages

- high reliability removes pregnancy fear
- allows spontaneity in sexual activity
- decreased menstrual disorders
- decreased incidence of benign breast tumors, ovarian cyst formation, and iron deficiency, anemia

Disadvantages

- possibility of serious health risks
- breakthrough bleeding, bloating, headache, irritability, mood changes, vaginal discharge
- breast discomfort, weight gain
- blood clots, liver tumors, gall bladder disease, the most serious disorders
- possible decrease in sexual response
- makes it more difficult to say no

3. IUD (Intrauterine Device)

An IUD is a foreign body--plastic coil, loop, or copper device--that is placed in the uterus by a physician. It most likely interferes with the implantation of the cluster of cells in the uterine lining. IUD's are not as frequently provided for teenagers because of the health risks involved.

Advantages

- only device required
- allows spontaneity in sexual activity
- requires medical supervision
- can be used for extended periods of time

Disadvantages

- heavier bleeding and cramps
- may spontaneously be expelled without the wearing knowing about it; may perforate the uterus
- pelvic infection may occur
- health risk of pregnancy occurs
- requires periodic checking by a physician

4. Condom

A condom is a rubber or plastic sheath worn on the erect penis. It acts as a physical barrier to trap the semen. It should be used with spermicides. Careful use is required--one must be used every time intercourse occurs, sufficient space should be left to collect semen, and withdrawal should occur soon after ejaculation to prevent slippage and spillage of semen.

Advantages

- free of side effects
- available over-the-counter
- encourages male responsibility
- effective in providing protection against sexually transmitted diseases if used every time intercourse occurs

Disadvantages

- may interfere with spontaneity
- requires careful planning and use
- may be embarrassing to purchase
- may be objectionable to some males
- may have negative image (used to prevent STD)

5. Diaphragm

A diaphragm is a shallow rubber cup that covers the cervix to prevent sperm from entering. It must be initially fitted by a physician who provides instruction on how to put it in place. It should be used with a spermicide and jelly or cream. It must be left in place for six hours after intercourse.

Advantages

- highly effective when correctly fitted and used consistently with spermatocide
- provides some protection against STD

Disadvantages

- requires fitting and careful instruction for use
- spermicide might be messy
- does not encourage spontaneity
- may be objectionable or uncomfortable for the user

6. Withdrawal

Withdrawal is the oldest and most widely used method of birth control throughout the world and is not at all dependable. It is commonly used among younger teenagers who are having intercourse for the first time. Self-control is required. Ejaculation must take place away from the entrance to the vagina or a "flash pregnancy" may occur if sperm enters the vagina. Some sperm may be present in pre-ejaculatory secretions.

Advantages

- no purchase required
- no visit to a physician required
- no planning required ahead of time
- better than no method at all--but not much

Disadvantages

- does not work
- frustration to couple if orgasm does not occur satisfactorily
- anxiety concerning time of withdrawal
- method is messy

7. Natural Family Planning - Rhythm Method

Periodic abstinence during the fertile period of a woman's cycle is based on a thermal or mucous method. The basal body temperature is lower prior to ovulation and rises after ovulation. Intercourse is avoided for several days before and after ovulation. Ovulation time can usually be determined by carefully recording basal body temperature each day, or by examination of mucus produced by the cervix. Some women are aware of ovulation because of slight discomfort in the lower abdomen.

Advantages

- no purchase of device
- no interference with sexual pleasure
- being knowledgeable about body changes and phases of the menstrual cycle

Disadvantages

- may be complicated to learn
- irregular cycles may make charting and interpretation difficult
- abstinence during fertile time may be undesirable
- not reliable for young people

8. Spermicides

Foams, creams, jellies and supppositories that contain chemicals to kill sperm on contact. Care must be taken to follow directions and use each time intercourse takes place.

Advantages

- no prescription
- lubrication is provided
- some protection against STD
- increases effectiveness
- condom and diaphragm

Disadvantages

- messy
- interferes with spontaneity
- short-lived requiring application for each time intercourse takes place

REFERENCES:

1. Herold, E.S. Sexual Behavior of Canadian Young People. Markham, ON: Fitzhenry and Whiteside, 1984.

2. Kane, Wm., ed. Healthy Living: An Active Approach to Wellness. Indianapolis: Bobbs-Merrill Educational Publishing, 1985.

TOPIC

Pregnancy and Drugs

STUDENT OBJECTIVES

The student will be able to:

1. recognize the main effects of some common drugs on maternal and fetal health,
2. recognize risks and complications of common drugs on maternal and fetal health,
3. propose health promotive behavior regarding pregnancy and health.

SUGGESTED STUDENT ACTIVITIES

. Participate in a lecture and discussion about effects and complications of common drugs on fetal and maternal health.
. View a film on drug-related birth defects.
. Review pamphlets on effects of drugs on maternal and fetal health.

REQUIRED MATERIALS

. Transparency: Maternal and Fetal Circulation; Pregnancy and Drugs
. Teacher Background Notes: Pregnancy and Drugs; Fetal Circulation
. Pamphlets

RESOURCES

1. Film: "Fetal Alcohol Syndrome"
2. Straight Facts About Drugs and Drug Abuse. Ottawa, ON: Health and Welfare Canada, 1983.

DESCRIPTION OF LESSON

I. INTRODUCTION

Although drugs and drug problems are not new, they are more prominent today than ever before. More drugs are available either at "home" or on the "street," more people are exposed to drugs, and more drug-related problems are evident than at any other time. Accurate information is needed about drugs and drug abuse so that young people will know the risks and complications of drug abuse.

DESCRIPTION OF LESSON

A drug is a substance other than food that changes the way the body functions. Some drugs are helpful and can aid in curing illness or preventing disease. Harmful drugs disturb the body's balance and harmony by affecting the function of key organs or body systems. While many drugs have legitimate uses, no drug should be used without proper caution and/or medical supervision.

If during pregnancy, harmful or dangerous drugs are taken by the mother, small molecules are transferred from the blood system on the maternal side of the placenta to the fetal circulation. Serious complications may result. This lesson deals with such common drugs of alcohol, nicotine and caffeine and the complications that their use may cause during pregnancy.

II. SUGGESTED STUDENT ACTIVITIES

A. Present a lecture describing the effects of alcohol, nicotine, and caffeine on maternal and fetal health. Use the transparency to illustrate the movement of molecules from maternal to fetal circulation.

B. Show a film on drug-related birth defects, and discuss key points.

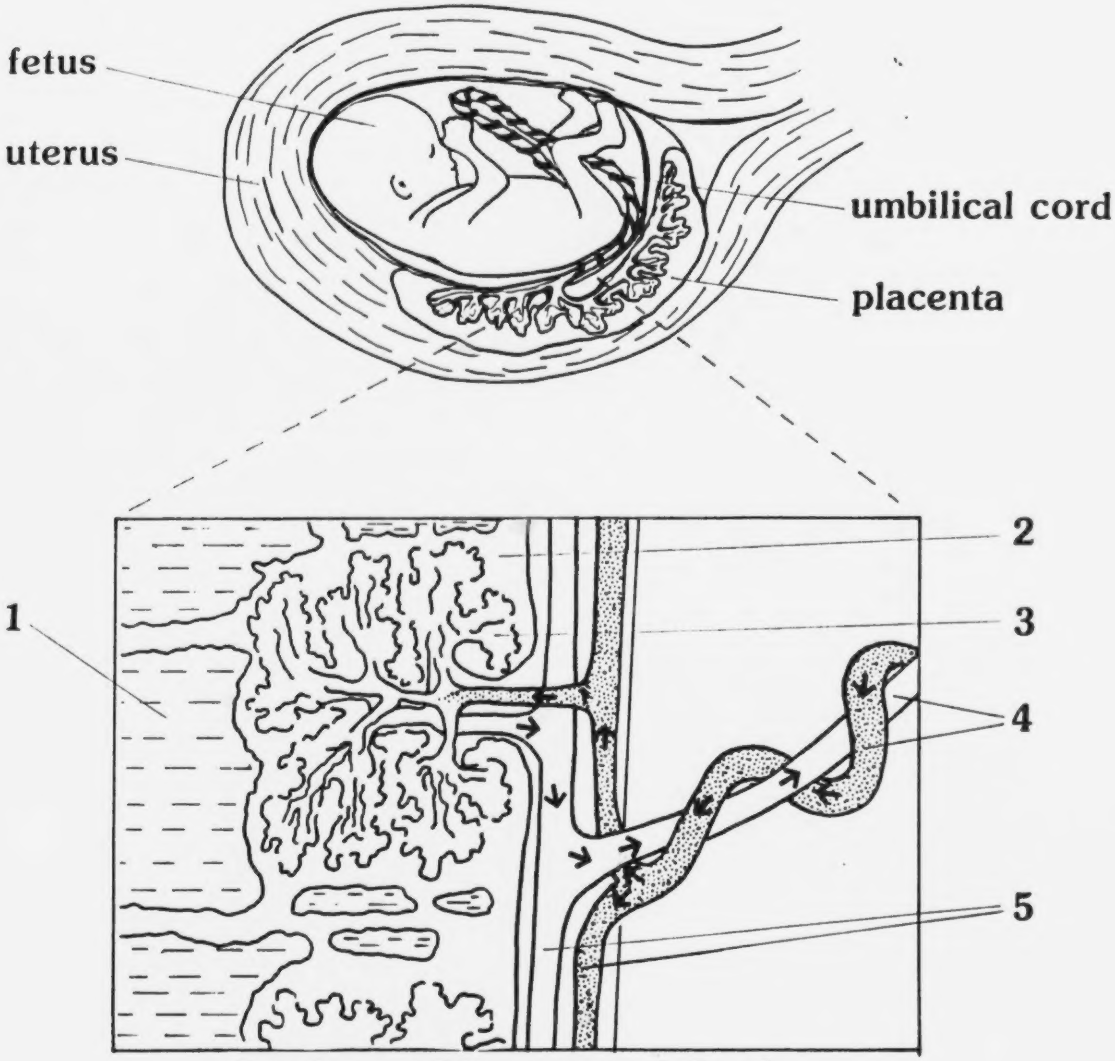
C. Have students read pamphlets from health agencies and summarize findings regarding drug use during pregnancy. Some pamphlets include:

- Should You Smoke During Pregnancy? Canadian Council on Smoking and Health (Manitoba Lung Association).
- Should I Take This during Pregnancy? Health and Welfare Canada, 1983.
- Drugs, Alcohol, Tobacco Abuse During Pregnancy. March of Dimes Birth Effects Foundation, (1275 Mamaroneck Avenue, White Plains, NY 10605, 1984).
- A Healthy Start. Alcoholism Foundation of Manitoba, 1983.
- Alcohol the Drug. Alcoholism Foundation of Manitoba, 1985.

III. SUMMARY

Some drugs are helpful and can aid the body's function, relieve pain, cure illness, or prevent diseases. Some common drugs can disturb the body's balance and affect body systems and organs in harmful ways. Serious complications to maternal and fetal health may occur when common drugs are taken into the body during pregnancy. No drug should be used without caution and medical supervision.

MATERNAL AND FETAL CIRCULATION


fetus
uterus
umbilical cord
placenta
1
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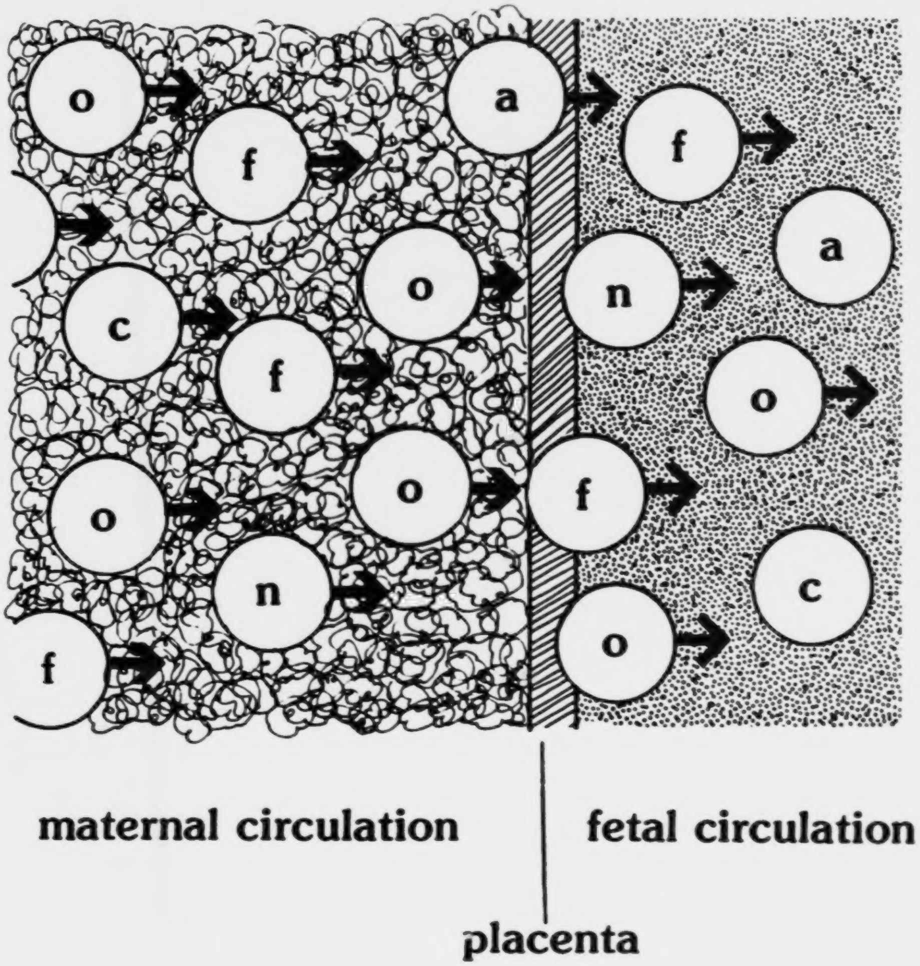
Portion of Placenta and Cord

1. uterus
2. hollow space
3. projection in placenta
4. vessels of the umbilical cord
5. blood vessels

PREGNANCY AND DRUGS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n nicotine
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a alcohol

TEACHER BACKGROUND NOTES: PREGNANCY AND DRUGS

A drug is a substance other than food that changes the way the body functions. Drugs act on different body cells in different ways. They may disturb the body's balance and harmony by affecting key organs such as the brain, heart, lungs, liver, kidneys. Small molecules of some common yet harmful drugs such as alcohol, tobacco, caffeine readily cross the maternal side of the placenta and enter the fetal circulation.

In addition to alcohol, nicotine, caffeine, such over-the-counter drugs as aspirin, such prescription drugs as birth-control pills, and such illicit drugs as marijauna may be hazardous to the health of the fetus. No drug or medication is advised during pregnancy without the doctor's approval.

Alcohol

Ethyl alcohol or beverage alcohol is made from sugars found in grapes or in grains such as rye. Short-term effects of alcohol include: drowsiness, dizziness, flushing, and euphoria. Larger doses cause confusion, slurred speech, double vision, stupor leading to death. Long-term effects include: damage to the liver, heart, stomach, and brain.

Alcohol easily crosses the placenta into the fetus; the fetal liver detoxifies alcohol at half the rate of the mother's. Women who use alcohol heavily, particularly in the first trimester of pregnancy, may have babies with physical, mental and behavioral abnormalities called Fetal Alcohol Syndrome. The major features of this disease are small eye slits, small head, length and weight deficiencies, as well as heart defects, mental retardation and learning deficiencies, behavioral disorders. Not all children born to women that drink alcohol show FAS. Some children affected may show classic features, while others may show fewer features only later in childhood. There is no safe level of alcohol for a pregnant woman. FAS can be prevented only if women abstain from alcohol during pregnancy.

Tobacco

Tobacco smoke contains tar, nicotine, carbon monoxide and other dangerous compounds. Short-term effects include increased heart rate and blood pressure, drop in skin temperature, faster breathing, and dulled appetite. Long- term effects: dependence, heart disease, closely linked to lung cancer. A pregnant woman who smokes places herself at risk in several ways. Babies of women who smoke are also at risk and tend to have lower birth weights and may show slower intellectual and physical development and behavioral changes. The risk of premature babies, spontaneous abortion (miscarriage) and stillbirth is greater to smoking mothers than non-smoking mothers. It is advisable that pregnant women abstain from smoking.

Fathers and mothers who smoke should be aware of the effects of smoking on babies after birth, and how second-hand smoke can irritate the baby's eye and nose passages and can block the baby's tiny airways in the lungs. The children of parents who smoke are more at risk of pneumonia and bronchitis than those of parents who don't.

Caffeine

Many common beverages such a tea, coffee, chocolate, cola drinks and certain medication (some headache pills and wake-up pills) contain caffeine. Regular use of coffee (four cups a day) leads to drug dependence and produces withdrawal symptoms of irritability, severe headache and fatigue. Short-term effects include increased body metabolism, blood pressure and body temperature, dulled appetite; headache and nervousness with larger doses. Long-term effects (regular use of eight cups of coffee daily) include: insomnia, anxiety, depression, stomach upset. Heavy caffeine use should be avoided throughout pregnancy as research links birth problems to heavy use.

Others

During pregnancy, the use of street drugs such as cannabis derivatives, amphetamines, hallucinogens (such as L.S.D.), tranquilizers, and narcotics may all be associated with deterious effects on the baby.

REFERENCE:

Straight Facts About Drugs and Drug Abuse. Ottawa, ON: Health and Welfare Canada, 1983.

TEACHER BACKGROUND NOTES: FETAL CIRCULATION

The fetus obtains all its oxygen and nutrients from the mother's circulation within the placenta and depends on her to eliminate wastes and carbon dioxide. Although there is no direct connection between the circulatory systems, exchanges take place across fetal capillary membranes which are surrounded by pools of maternal blood.

- Blood from the maternal side of the placenta flows into spaces that surround projections containing fetal capillaries.
- Blood flows from the fetus to the placenta by way of two umbilical arteries which subdivide into capillaries within the projections.
- Oxygen and nutrients from the maternal blood diffuse across the thin membranes of the capillaries into the fetal blood; wastes and carbon dioxide diffuse into the maternal blood.
- Fully oxygenated blood returns to the fetus through the umbilical vein.
- The umbilical vein enters the abdomen of the fetus at the umbilicus and ascends to the liver where the vessel divides. One branch enters the liver; the other branch joins a vessel that enters the right side of the fetal heart.
- Blood circulation to the entire fetus occurs--nutrients are delivered and wastes are picked up.
- Blood returns to the placenta by two umbilical arteries. It circulates to the capillaries; wastes are eliminated and nutrients are picked up.

Note: It is in this manner that small disease organisms such as syphilis and the molecules of drugs such as alcohol, caffeine, and nicotine may be transported to the fetus.

TOPIC	Sexually Transmitted Diseases
STUDENT OBJECTIVES	The student will be able to: 1. interpret data about the spread of sexually transmitted diseases, 2. recognize the characteristics and complications of common sexually transmitted diseases, 3. identify local and provincial services or professionals who provide treatment for sexually transmitted diseases, 4. explain prevention measures for sexually transmitted diseases.
SUGGESTED STUDENT ACTIVITIES	. Using a table of STD rates among 15 to 19 year olds, discuss how sexually transmitted diseases spread. . Describe common sexually transmitted diseases and their clinical characteristics and complications. . Propose ways to prevent sexually transmitted disease.
REQUIRED MATERIALS	. Teacher Background Notes: Common Sexually Transmitted Diseases; Facts About Sexually Transmitted Diseases
RESOURCES	1. Kane, Wm., ed. Healthy Living: An Active Approach to Wellness. Indianapolis: Bobbs Merrill Educ. Publishing, 1985. 2. Herold, E.S. Sexual Behavior of Canadian Young People. Markham, ON: Fitzhenry and Whiteside, 1984. 3. Pat Matusko, STD Control, Manitoba Health. 4. Meek, L.B., and P. Heit. Venereal Disease - STD. Toronto, ON: Merrill, 1982.

DESCRIPTION OF LESSON

I. INTRODUCTION

The term, STD, an abbreviation for Sexually Transmitted Disease, has replaced the other term for venereal disease, VD. STDs encompass a wider range of diseases than VD did (such as pubic lice, scabies and hepatitis B) and include those spread mainly, although not exclusively, through sexual intimacy.

The Public Health Act does not require that all STDs be reported to the Health Department. Those reportable are: chancroid, gonorrhea, syphilis and chlamydia.

DESCRIPTION OF LESSON

Each STD is caused by a specific organism and has specific characteristics, although those characteristics may be hidden or go unnoticed. Although most STDs are curable, there is no immunity from them. A person can become repeatedly infected and can be host to more than one STD at a time. Many serious risks and consequences accompany STD. General warnings to heed are: painful urination, sores or itching in the genital area, unusual discharge from the penis or vagina. Medical attention, treatment and prevention are imperative if STD is suspected.

This lesson serves as an overview to STD. The Environmental Health objectives (2.2-2.4) of the Grade 9 Health curriculum deal with the topic in greater detail.

II. SUGGESTED STUDENT ACTIVITIES

A. Using a copy of the table of STD rates among 15-19 year olds in Canada, 1964-1982 (Herold, p. 139), discuss the possible reasons for the increase in rates.

B. In a lecture format, describe common STDs, their characteristics and complications. Review the Fact Sheet with the class. See Teacher Background Notes: Common STDs.

C. Identify community resources for the prevention and treatment of STDs. Encourage the class to develop a list of preventive measures. Suggestions include:

1. Avoid sexual intimacy.
2. Be knowledgeable of and able to recognize symptoms and the need for diagnosis, treatment, and reporting.
3. If sexually active:
   - recognize symptoms,
   - seek medical attention and diagnosis,
   - comply with treatment,
   - encourage sexual contacts to seek treatment,
   - practice careful sexual hygiene (wash before and after intercourse),
   - use condoms.

III. SUMMARY

STDs are serious diseases. It is important to be knowledgeable of them and take measures to prevent them.

TEACHER BACKGROUND NOTES: COMMON SEXUALLY TRANSMITTED DISEASES (STDs)

Disease (cause)	Reportable	Clinical Characteristics
Herpes Simplex type 2 or genital herpes (virus)		Small painful blisters or ulcers erupt on skin of genital area sometimes associated with intercourse. Sores crust over and heal. Subsequent outbreaks occur. Disease is associated with increased risk of cancer of the cervix. Infants born to mothers who are infectious at the time of birth are at risk of birth defects/death. No effective drug treatment yet.
Genital warts (virus)		Warts that appear on genital and anal areas frequently spread through sexual intimacy. The warts may have a cauliflower-like appearance and may appear in groups. They may be treated or surgically removed.
Gonorrhea (bacteria)	Yes	Burning, itching and inflammation of genital and urinary membranes. Males exude whitish-yellow discharge. Women may notice slight vaginal discharge. If untreated, reproductive organs may be infected and sterility may result. This is known as P.I.D. or Pelvic Inflammatory Disease. Newborn baby's eyes may become infected if mother is infected.
Chancroid (bacteria)	Yes	Painful sores filled with pus in the genital area occurring 1-5 days after intercourse. If untreated, they may infect lymph glands causing swelling and a large open sore.
Syphilis (bacteria)	Yes	A three-stage infection transmitted by intercourse: . primary state - a painless sore called a chancre, . secondary stage - a skin rash, . tertiary stage - damage to heart, nervous system or other organs.

Disease (cause)	Reportable	Clinical Characteristics
Syphilis (bacteria) (Cont'd)	Yes	Syphilis responds well to drug treatment especially in the early stages. Risk of infection of the fetus of a mother with untreated syphilis is very high and abnormalities or death of the baby may occur.
Nongonococcal urethritis (may be caused by Chlamydia trachomatis)		Inflammation or infection of the urethra accompanied by burning and itching around the urethra and burning on urination. Watery discharge appears 1-4 weeks after infection. If untreated, may result in infections of the bladder or testes, inflammation of the cervix, and pelvic inflammatory disease (fallopian tube infection may result in sterility). During birth, the disease can infect and damage a baby's eyes.
Trichomoniasis (Protozoan)		An infection of the vagina. Greenish-yellow discharge causes itchy red and painful genital areas. Men may have a slight discharge from penis. Organism can live outside the body for several hours on objects such as washcloths and soap. Disease is most noticeable in women.
Candidiasis (yeast)		Severe vaginal itching and odorless vaginal discharge which is white and cheesy. A rash or small sores may appear in genital area. Men may have a slight irritation of penis. Cleanliness of genital area is important during treatment. If untreated, reinfection occurs. Babies born to infected mothers can develop "thrush," a yeast infection in the baby's mouth. Disease is more noticeable in women.

Disease (cause)	Reportable	Clinical Characteristics
AIDS* acquired immunodeficiency syndrome (virus)		AIDS is a new disease that we are still learning about. It may be transmitted by sexual intercourse, blood and blood products. Other possible routes of transmission are being studied. During the very early stage there may be no symptoms. The virus attacks the body's natural ability to fight disease, and it becomes vulnerable to unusual serious illnesses. The following signals, if they persist for more than two weeks, should be reported to the doctor: . extreme persistent fatigue . fever . night sweats . severe unexplained weight loss . persistent diarrhea . harsh dry cough . thick grey-white coating on the tongue or throat . swelling of glands in neck, armpits or groin The most common life-threatening illnesses contacted by AIDS patients are: . Pneumocystis carinii pneumonia--a rare form of pneumonia diagnosed in 50 per cent of the AIDS patients in Canada; . Kaposi's sarcoma--an unusual cancer found in 25 per cent of AIDS patients. Prevention is the key to control of this illness at present.

* SOURCE OF INFORMATION: AIDS in Canada: What You Should Know (Ottawa: Health and Welfare Canada, 1985).

TOPIC	Sexual Assault Prevention

STUDENT OBJECTIVES

The student will be able to:

1. examine some aspects of Canadian law regarding sexual assault,
2. identify factors that might precipitate a sexual assault,
3. identify ways to prevent sexual assault,
4. describe consequences surrounding sexual assault.

SUGGESTED STUDENT ACTIVITIES

- Discuss myths about the issue of sexual assault.
- Participate in a lecture and discussion about sexual assault.
- View a film on sexual assault.
- List ways of preventing sexual assault.

REQUIRED MATERIALS

- Teacher Background Notes: Sexual Assault; Values and Decision-Making
- Teaching Aids: Fact or Fiction Worksheet
- Film: "Beware the Rapist"

RESOURCES

1. Bignell, Steven. Sex Education: Teacher Guide and Resource Manual. Santa Cruz, CA: Network Publications, 1982.
2. Boyle, Christine, L.M. Sexual Assault. Toronto: The Carswell Company Limited, 1984.
3. Sexual Offences Against Children. Vol. I and II, Report of the Committee on Sexual Offences Against Children and Youth. Ottawa: Ministry of Supply and Services Canada, 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

Introduce this lesson by explaining that rape is only one type of sexual assault. Sexual assault can be any type of sexual harassment. Rape is a crime of violence. It is a physical attack in which the offender forces the victim to have sexual intercourse with him/her against the victim's will. Rape has been a crime for much of

Canadian and English history. In 1869, rape was made a federal criminal offence punishable by death. Three years later an alternative punishment of life imprisonment for any term not less than seven years was sanctioned. A provision for whipping convicted rapists was in effect from 1921 to 1972. (Sexual Offences Against Children, Volume I, The Badgley Report, pp. 305-306.)

In 1983 amendments were made to the Criminal Code. Although the term "sexual assault" is not defined in the Criminal Code, it means an assault that is directed at a person's sexual organs, or an assault which is sexually motivated. Accordingly, it covers a wide variety of behavior.

II. SUGGESTED STUDENT ACTIVITIES

A. Distribute the Fact and Fiction Worksheet. Have students complete the worksheet. Discuss the answers, eliminating some of the fiction or myths regarding sexual assault. Emphasize the following points:

- Sexual assaults cover a wide range of activities.
- Most rapes are planned.
- Many rapists (close to 50%) know the victim.
- One half of all rapes occur in a residence.
- Research shows very little evidence that provocative behavior on the part of the woman is responsible for the attack.
- The attacker has the advantage of surprise; the victim may fear for his/her life.
- Any act of sexual intercourse to which the victim does not consent is rape; having intercourse with an individual 14 years of age or under, with or without consent, is rape.
- Men can be raped by men; women can sexually abuse men.
- Victims do not enjoy being attacked and abused; they feel powerless, humiliated and degraded.

Questions for discussion:

1. What influences peoples' attitudes regarding sexual assault? (i.e., media)

B. View a film on sexual assault. In particular, watch for factors that might precipitate a sexual assault.

Questions for discussion:

1. List some factors from the film that led to sexual assault. Consider four categories:

1. behavior that a rapist may look for in a victim

   - hesitation, uncertainty, fear
   - confusion
   - fumbling (e.g., looking for keys)

2. ways to avoid a vulnerable situation

   - be aware of your surroundings
   - invite friends to accompany you on outings
   - ask family members to meet you, e.g., underground parking lots
   - avoid risk-taking
   - avoid isolated spots
   - do not hitchhike or take rides with a stranger

3. ways to protect yourself at home

   - not including your name and address on a key ring
   - changing locks when necessary
   - having home securely locked (windows and doors)
   - not letting in a repairman unless you know the request is legitimate

4. ways to escape a potentially dangerous situation

   - assert yourself - say No
   - look for support people to talk with if you suspect a sexual assault may take place (trust your hunches)
   - minimize risk-taking

C. Participate in a lecture and discussion about the consequences of an assault. These may include for the victim:

- feelings of fear, anxiety, anger
- feelings of guilt, shame, responsibility
- fear of another attack
- fear of being unable to cope with a sexual relationship
- some physical symptoms, fear of infection and pregnancy
- disturbances in sleep patterns; nightmares
- humiliation; for male victims, fear of social attitudes concerning the male victim

Identify all of the universal values that are violated in a sexual assault.

Stress the importance of the following if rape occurs:

1. The victim must ask the assailant to stop; in court the assailant could argue that the victim had consented.
2. Immediately, following an assault, it is essential that the victim avoid showering or changing clothes as these actions may destroy the evidence of the assault.
3. The victim should see a doctor immediately to attend to physical injury, to be reassured about her/his physical safety and to gather evidence in the event of charges being laid.
4. Report the assault to the police.
5. Contact a support group for counselling, e.g., The Klinic.

III. SUMMARY

Sexual assault is against the law. The new definition of sexual assault includes a wide variety of sexual offences all dealing with sexually motivated behaviors.

Stress the importance of using common sense in the matters of personal safety, avoiding potentially dangerous situations and building support systems to avoid danger.

Stress also that it is important to report a sexual assault. This action may contribute to the safety of others.

TEACHER BACKGROUND NOTES: SEXUAL ASSAULT

Definition

Section 244 (1) of the Criminal Code states:

"A person commits an assault when

(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;

(b) he attempts or threatens, by an act or gesture, to apply force to another person, if he has, or causes that other person to believe upon reasonable grounds that he has present ability to affect his purpose; or

(c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs."

(Sexual Abuse Against Children, Vol. 2. The Badgley Report, pp. 1294-1295.)

This legislation says that sexual assault is primarily an act of violence, not of passion; it is an assault with sex as the weapon.

Research indicates that it is impossible to classify all sexual assaulters in one category. Some use aggression as a means to sexual activity; others use violence as an end in itself. The person who commits a sexual assault exploits the vulnerability of his/her victim in order to satisfy the need to show aggression. A sexual assault leaves a victim feeling disgusted, humiliated and ashamed. Victims feel a sense of powerlessness as well as confusion and disorientation.

The following are some types of sexual assault:

1. profane, offensive language
2. obscene telephone calls
3. sexual harassment
4. child molestation
5. indecent assault
6. indecent exposure
7. gross indecency
8. attempted rape and rape
9. incest
10. indecent act

Section 246.2 of the Criminal Code provides that:

"Every one who, in committing a sexual harassment,

(a) carries, uses or threatens to use a weapon or an imitation thereof

(b) threatens to cause bodily harm to a person other than the complainant

(c) causes bodily harm to the complainant, or

(d) is the party to the offence with any other person

is guilty of an indictable offence and is liable to imprisonment for fourteen years."

(*Sexual Offences Against Children*. Vol. 1, The Badgley Report, p. 308.)

Bodily harm consists of any hurt or injury that interferes with the victim's health and comfort and is more than trifling in nature.

Pregnancy occurs in about one in twelve reported rapes.

There is a danger of sexually transmitted disease being passed to the victim in a sexual assault.

Section 236.3 of the Criminal Code provides that:

"(a) Every one commits an aggravated sexual assault who, in committing a sexual assault, wounds, maims, disfigures or endangers the life of the complainant.

(b) Every one who commits an aggravated sexual assault is guilty of an indictable offence and is liable to imprisonment for life."

(*Sexual Offences Against Children*. Vol. 1, The Badgley Report, p. 308.)

This is the most serious form of sexual assault.

Section 244(3) of the Criminal Code provides that:

"No consent is obtained where the complainant submits or does not resist by reason of

(a) the application of force to the complainant or to a person other than the complainant;
(b) threats or fear of the application of force to the complainant or to a person other than the complainant;
(c) fraud; or
(d) the exercise of authority."

(*Sexual Offences Against Children*. Vol. 1, The Badgley Report, p. 309.)

It is important for teens to be aware of Canadian laws about unaceptable sexual behavior and be better informed about prevention of sexual abuse and exploitation. They should know, for example, that:

- If young people go beyond adolescent "petting," any given consent does not apply when a girl is under the age of 16 and anal or genital sex is involved.

- Under current Canadian law, there is an absolute prohibition against any male having sexual intercourse with a female who is under 14 years and who is not his wife. An accused found guilty of the offence is liable to imprisonment for life. Consensual intercourse involving girls 14 or 15 is prohibited in a qualified form. The court may find the accused not guilty if the evidence does not show that the accused was more to blame than the female for sexual behavior.

- Under current Canadian law, two persons must be 21 or older to be assured that, apart from incest, none of their private consensual sexual conduct constitutes a criminal offence.

- Gross indecency and buggery (anal sex) with another person are prohibited for both boys and girls up to age 21.

(Sexual offences Against Children: Summary. The Badgley Report, pp. 18-21.)

Sexual Assault Findings

Canadian Surveys indicate the following results (Sexual Offences Against Children, Vol. II, The Badgley Report).

1. More offences are committed in the summer.
2. Almost half of the offences had been committed in private places (homes) and about a third had occurred in public places.
3. Of offences committed in private places, females were twice as likely as males to have offences committed against them in their homes.
4. In about one in five offences, the victim and the convicted offender had been living in the same household when the offence was committed.
5. Serious sexual acts against minors are not rare occurrences.
6. Previously convicted offenders more frequently had physically injured the victim.
7. Overall, about one in eight victims had been physically injured.
8. Virtually all convicted offenders have been males. This survey found that 1.1% were women.
9. Of convicted male offenders having single victims, four out of five had committed heterosexual offences and one in five had committed a homosexual offence.
10. 14% of convicted offenders were under 21 years old; 43% in the 21-40 year old grouping; 18.4% in the 41 years old and older group.
11. One in three offenders had no prior criminal record.
12. Male victims, on average, were younger than female victims.
13. On average, proportionally more serious sexual acts were committed against female victims than against male victims.

14. Nine out of ten offenders had grown up in homes having both natural parents and siblings; about one in eight had been taken into custody by a child protection agency; about three in five were, or had been, married.
15. Fathers--natural, step, foster, adoptive, and common-law--made up one in five convicted offenders.
16. Three out of four offenders were known to their victims.
17. About one in fourteen convicted offenders had had one or more accomplices in committing the offences.
18. Dangerous child sexual offenders differed from other convicted offenders; proportionately more had no siblings and a larger number had came from broken homes; about one-third had been removed by child protection agencies from their homes.

REFERENCES:

Boyle, Christine, L.M. Sexual Assault. Toronto: The Carswell Company, Limited, 1984.

Sexual Offences Against Children. Volume I and II. Report of the Committee on Sexual Offences Against Children and Youth. Ottawa: Ministry of Supply and Services Canada, 1984.

TEACHER BACKGROUND NOTES: VALUES AND DECISION-MAKING

There are 'right' and 'wrong' values depending on an individual's and a society's religious beliefs, personal beliefs and cultural mores. However, there exists a set of universal or core principles of morality. Over time, civilizations have held eight universal or objective values in common. They include:

1. The Law of General Beneficience - showing kindness and good will to others
2. The Law of Special Beneficience - showing kindness and good will to family and friends
3. Duties to Parents, Elders and Ancestors - showing respect for parents and elders
4. Duties to Children and Posterity - showing respect and reverence for children, who will become our future generations
5. The Law of Justice - showing honesty, sexual justice and equal justice to all
6. The Law of Good Faith and Veracity - having faith and trust in mankind
7. The Law of Good Mercy - having mercy on all those who are in need
8. The Law of Magnanimity - overlooking injury or insult; not hurting or exploiting others either directly or indirectly

Such universal values or core moral precepts, transcend cultural and religious differences. Universal values are supported by the mandate of the school system which states "While it is impossible to identify a particular position on a given set of values that should be conveyed to all, many qualities of mind and character are clearly seen as desirable and should be developed, e.g., honesty, respect and concern for others, empathy and tolerance, cooperativeness, resourcefulness, self-reliance, open mindedness, concern for societal issues and an open attitude towards social change, respect for legitimately constituted authority, capacity for hard work, willingness to become involved in genuine search for solutions to problems." Thus values in health education should focus on a sense of caring and respect for family and others, kindness, honesty, compassion and respect for self.

REFERENCES:

1. Gow, Kathleen. Yes, Virginia, There Is Right and Wrong. Values Education Survival Kit. Toronto: John Wiley, 1980.

2. Manitoba Department of Education. Administrative Handbook. Winnipeg: The Department, 1983. Section 3, p. 3.

FACT OR FICTION WORKSHEET

On the line preceding each statement, write fact if the statement is true or fiction if the statement is not true.

__________ 1. Having sexual intercourse with a female under 14 years of age is considered rape.

__________ 2. A person who threatens another person sexually is committing a sexual assault.

__________ 3. Sexual assaults are only experienced by women.

__________ 4. A woman who is raped cannot become pregnant.

__________ 5. A residence is the safest place for women if they wish to be safe from sexual assault.

__________ 6. An executive who pinches his/her secretary on the bottom is guilty of sexual assault.

__________ 7. A person who exposes herself/himself in an elevator is guilty of sexual assault.

__________ 8. A "streaker" is guilty of sexual assault.

__________ 9. Most rapists are strangers to the victim.

__________ 10. Young males constitute the largest number of offenders.

__________ 11. Most rapes occur in back alleys or to women who hitchhike or jog.

__________ 12. Women provoke rape attacks by their clothing, gestures or behavior.

__________ 13. Rape is impossible without the consent of the victim.

__________ 14. Women enjoy rape.

Answer Key: 1. fact 2. fact 3. fiction 4. fiction 5. fiction 6. fact 7. fact 8. fact 9. fiction 10. fiction 11. fiction 12. fiction 13. fiction 14. fiction

GRADE 9 **3.0 Dilemmas and Issues** **Lesson 3.10**

TOPIC

Family Change: Divorce

STUDENT OBJECTIVES

The student will be able to:

1. recognize the adjustments of a family during separation or divorce,
2. identify ways to encourage individuals, families and communities to offer support for divorcing families.

SUGGESTED STUDENT ACTIVITIES

- View a film on a family experiencing divorce.
- Discuss questions relating to family change: separation and divorce.
- Compile a list of caring and supporting behavior for divorcing families.

REQUIRED MATERIALS

- Teacher Background Notes: Divorce; Divorce Act, 1985
- Film: "Divorce" (Manitoba Health)
- Teaching Aid: Family Support Worksheet

RESOURCES

1. Henderson, S. Dimensions of Life. Cincinnati, OH: South-Western Publishing Co., 1985.
2. Leavenworth, C., et al. Family Living. Prentice-Hall, 1982.
3. Peters, John. Divorce: Social Problems in Canada. Toronto: Guidance Centre, Faculty of Education, University of Toronto, 1979.
4. Sasse, C. Person to Person. Peoria, IL: Bennett Publishing Company, 1981.
5. Smith, R., and M. L. Apicelli. Family Matters: Concepts in Marriage and Personal Relationships. Encino, CA: Glencoe Publishing, 1982.
6. Payne, Julian D. Payne's Commentaries on the Divorce Act, 1985. Don Mills: Richard De Boo, 1986.

DESCRIPTION OF LESSON

I. INTRODUCTION

Explain that this lesson examines how separation and divorce affects the family. Divorce can occur for many different reasons, the particular causes varying from relationship to relationship. The time preceding a separation or divorce is often a very upsetting and confusing time for family members. Because parents tend to view the problem as one strictly between the adults, they usually do not discuss their difficulties with the children. The uncertainty children have to deal with often compounds the initial difficulties.

Children express concern about what will happen to them following the divorce. Parents sometimes have difficulty discussing custody and living arrangements with their children.

Children often feel threatened if they must choose one parent over another or if they are caught in the midst of parental conflict. They may worry about losing the love of one parent if they show affection to the other.

Often children assign blame to themselves; they assume that the divorce is their fault. This often happens when the child knows there is a problem, but no one is talking about it.

Divorce is a particular kind of family breakdown and cuts across the entire population. Family members may still visit after the divorce. Parents do not become non-parents. A divorce aligns the family in a new and different manner. It does not mean the permanent end of these relationships.

Most people believe that divorce is bad for children. However, this stereotyped idea is not always so. In conflict-riddled homes, children may suffer more than in divorced homes. It is possible that many children adjust better to divorce than they did to their former two-parent home. However, children who believed their parents were happy are likely to be shocked by the divorce. They are apt to be so upset that their adjustment is difficult.

Most children adjust to the divorce in the same way that their parents do. If parents feel that divorce is the best solution for their marriage problems, the children will probably agree.

II. SUGGESTED STUDENT ACTIVITIES

A. Have students view a film and discuss questions relating to the separation or divorce.

Questions for discussion:

1. What feelings are partners likely to have during the separation and divorce?
2. Why does the divorce often cause worry or anxiety for family members?
3. What decisions must be made during the parental divorce?
4. What are some adjustments ex-husbands and ex-wives must make after the divorce?
5. What are some factors which determine how children adjust to divorce?
6. What factors may account for a higher divorce rate today than in previous times?

B. Explain that many people offer support to a family in a time of crisis, such as illness, unemployment or death. Flowers, food, a card or a letter may be sent. Friends gather to offer support. In a divorce, little such support is offered. Often divorcing people become isolated just when they are most in need of help. Divide students into small groups. Distribute the Family Support Worksheet and ask students to develop a list of ways individuals or friends, families and communities can provide support for families experiencing divorce. Have groups read their lists to the class. Discuss how their suggestions might be implemented.

III. SUMMARY

Going through a divorce can be a difficult process for parents and children. Divorces occur for a variety of reasons. Essentially, it involves a problem between the adults. Children are not at fault. Encourage students to be aware of how they might support a person experiencing this family change.

TEACHER BACKGROUND NOTES: DIVORCE

When a couple marries, they pledge to marry for life. However, because of numerous pressures, some of which are common to marriage, some marriages fail. Separation and the resulting divorce are relatively commonplace in today's society. "The number of marriages which involve at least one previously married partner has been constantly rising during the last ten years. In 1980, 26.5 percent of all marriages involved a previously married partner. The single most important factor responsible for this trend is the increase in divorce." (Eichler, p. 231.)

In 1967, there were 2,497 (1.5%) divorced bride/divorced groom marriages; in 1980, in the same category, 13,873 (7.3%) marriages occurred. The statistics of marriages between one single partner and one widowed partner and between two widowed partners show a decrease. All categories of marriage involving at least one divorced partner have increased (Source: Statistics Canada, Catalogue 82-205, Vol. II, Marriages and Divorces. 1971, p. 81 t. 13; 1980, p. 8 t. 5).

SEPARATION, also known as "limited divorce," can be an informal or a legal separation. If the separation is informal, then the spouses live apart, but none of the other marital rights and responsibilities change. If the separation is legal, then the spouses do not reside together, and the courts will set down conditions such as financial support, child custody, etc. The couple may not remarry until a legal divorce has been granted.

DIVORCE is the legal dissolving of a marriage commitment complete with legal property, support, and custody agreements. Both spouses are free to marry again. Divorce is a legal term. Only people who are legally married can divorce.

FACTORS CONTRIBUTING TO DIVORCE

Marriages fail for many reasons, and no one can predict who will divorce and who will not. However, several factors have been identified as being related to divorce. These following factors appear to be present in families who seek and gain divorce, but are not considered to be its cause.

1. Poor economic status
2. Infidelity
3. Teenage marriage
4. Mental and physical cruelty
5. Lack of education
6. Different backgrounds, social class, faith or ethnic origin
7. Short acquaintance or engagement
8. Family disapproval of marriage
9. Opposing views of roles of husbands and wives

10. Lack of formal membership in any religious group
11. High mobility
12. Occupational stress, i.e., danger or travel frequency
13. Significant differences in age of spouses
14. Previous marriages

ADJUSTMENT TO DIVORCE

Divorce is a painful and depressing experience for all family members. Both spouses and children must reorganize their lives to meet and adjust to the change.

EFFECTS ON ADULTS

Both spouses experience emotional and financial problems as a result of divorce. After the security of an intimate marriage relationship, divorce brings on feelings of loneliness. Both spouses adjust to their independent status and establish new social networks. Feelings of failure and the loss of friends are commonplace with divorce. Often, counselling and therapy may be required to help both through the grief process: 1) denial, 2) anger, 3) bargaining, 4) depression, 5) acceptance.

With the loss of a husband, some women experience an identity crisis. They may need to find a job. Even with a job, many experience a drop in financial status and standard of living, because of their possible lack of education and training. Some men also face an increased financial burden.

TEENAGE MARRIAGE

Teenage marriages often fail because of the partners' lack of education and training. "In recent years fewer teenagers have married. For example, in 1981, 17.8% of nineteen-year-olds were never married, compared with 20.3% who were married in 1971" (Statistics Canada, 1971 and 1981 Census). There were fewer adolescents in Canada during the latter census.

The survival rate of young marriages is low. "The divorce rate among couples who married before the age of 19 is about three times as high as among couples who married after the age of 20."

In many instances, the young woman is at a financial disadvantage, particularly if she has not had the opportunity to further her education and develop job skills.

REFERENCE:

Schelesinger, Benjamin. Families: Canada. Toronto: McGraw-Hill Ryerson Ltd., 1979, p. 86.

EFFECTS ON CHILDREN

When couples divorce, children suffer as well. How seriously they are affected depends upon the degree to which they were caught in the conflict during the divorce process and settlement, and, even more importantly, the degree to which the spouse with custody has adjusted to the divorce. Children appear to adjust to divorce more readily when parents adjust readily.

Some serious adjustment behavior may occur in children of divorce. Many children blame themselves for the divorce or deny it has happened. Some blame a particular parent and therefore withdraw from the one they believe is at fault. They may exhibit sadness, depression, withdrawal, antisocial behavior, academic problems, and personality maladjustments. In later years, these children may regard their childhood as an unhappy time.

In spite of this, most children do not bear the scars of divorce forever. Parents can hasten and ease their own adjustment period through counselling and therapy.

REFERENCES:

Eichler, Margaret. Families In Canada Today. Toronto: Gage Publishing Limited, 1983.

Herold, Edward S. Sexual Behavior of Canadian Young People. Markham, ON: Fitzhenry and Whiteside Limited, 1984, p. 124.

Schlesinger, Benjamin. Family Matters: Concepts in Marriage and Personal Relationships. Encino, CA: Glencoe Publishing, 1982.

INTRODUCTION

Marriage and Divorce in Canada

The *Divorce Act*, S.C. 1967-1968, c. 24, which introduced the first dominion-wide, and, therefore uniform, divorce regime in Canada, has remained substantially unchanged since it came into force on July 2, 1968. Between 1966 and 1985, the incidence of divorce in Canada has increased approximately 500 per cent. Current projections indicate that 40 per cent of all marriages in Canada will be terminated by divorce. Approximately 50 per cent of all marriages that are dissolved have lasted for less than 12 years. Canadians are divorcing at a younger age than ever before. Less than one per cent of all divorce petitions are dismissed by the courts and only five per cent of all divorce cases are contested at the time of the trial. It has been conservatively estimated that Canadians have spent no less than $500 million in legal fees over the last decade in seeking the judicial dissolution of their marriages.

The Need for Reform

The need for reform of Canada's divorce laws has been widely acknowledged since the publication of the Law Reform Commission of Canada's *Report on Family Law* in March 1976. There is now increasing awareness that reliance on the traditional adversarial legal process and the fault-orientation of substantive law tends to provoke hostility and bitterness between the spouses and has aggravated the emotional trauma of spouses and children that are a natural concomitant of marriage breakdown. In an attempt to foster the more constructive resolution of family disputes on marriage breakdown, the Law Reform Commission of Canada recommended that marriage breakdown should constitute the sole criterion of divorce in Canada and that Unified Family Courts should be established across Canada with an exclusive and comprehensive judicial jurisdiction over family disputes. These recommendations, though resulting in some federal initiatives, including the establishment of Unified Family Courts in some urban centres across Canada, have yet to attract the wholehearted support of the federal government. Although subsection 8(1) of the *Divorce Act, 1985* establishes the breakdown of marriage as the sole basis for divorce, the means of proving such marriage breakdown under subsection 8(2) of the Act encompasses both fault and non-fault considerations.

The Objectives of Divorce Reform

Although it has been commonly asserted that divorce laws should seek to buttress the stability of marriage, it is a mistake to assume that divorce laws either encourage or discourage marriage breakdown. Legislative measures and

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governmental policies to promote the stability of marriage must be found in sources other than divorce legislation.

The primary objectives of a sound divorce law are (i) to facilitate the legal termination of marriages that have irretrievably broken down with a minimum of hurt, hostility, humiliation and hardship; (ii) to promote an equitable disposition of the economic consequences of the marriage breakdown; and (iii) to ensure that reasonable arrangements are made for the upbringing of the children of divorcing parents. The extent to which these objectives have been attained by the enactment of the *Divorce Act, 1985* deserves close attention.

Summary of Basic Changes under *Divorce Act, 1985*

In light of the aforementioned objectives of divorce reform, it is appropriate to examine the changes introduced by the *Divorce Act, 1985* under the following headings: (1) Jurisdiction; (2) Grounds and bars to divorce; (3) Economic rights and obligations; (4) Parenting rights; and (5) Process.

1. *Jurisdiction*

Sections 3 to 6 of the *Divorce Act, 1985* define the jurisdictional competence of a court to entertain proceedings for a divorce or for corollary relief respecting spousal or child support and child custody or access. Subject to the discretionary powers of transfer conferred by section 6 of the *Divorce Act, 1985*, which applies where the proceedings include a contested application for child custody or access, the primary basis for the exercise of jurisdiction under the Act is the "ordinary residence" of either spouse within the province wherein the proceedings are commenced. The former jurisdictional requirements of section 5 of the *Divorce Act*, R.S.C. 1970, c. D-8 respecting domicile and "actual residence" have been abandoned. More importantly, an exclusive jurisdiction to vary, rescind or suspend an order for corollary relief no longer vests in the court that granted the order. Indeed, that court will, subject to subsection 6(3) of the *Divorce Act, 1985*, lack such jurisdiction unless either of the former spouses is ordinarily resident in the province or both former spouses accept the jurisdiction of that court.

Subject to qualification under section 20 of the *Divorce Act, 1985*, which relates to the enforcement of corollary relief orders, subsection 2(1) of the *Divorce Act, 1985* defines the "court" of a province or territory that is competent to entertain proceedings arising pursuant to the Act. This definition empowers the Lieutenant Governor in Council of a province to designate a Unified Family Court that is presided over by federally appointed judges as a court of competent jurisdiction for all purposes of the *Divorce Act, 1985*.

Although the substantive right to appeal (see *Adoption of Y.P.; J.F.C. et M.R. c. R.R. et Le Tribunal de la Jeunesse*, [1983] R.D.J. 330 at 331 (Que. C.A.)) is expressly regulated by section 21 of the *Divorce Act, 1985*, the determination of the appropriate appellate court and the practice and procedure of such a court are delegated to provincial authorities pursuant to the definition of "appellate court" in subsection 2(1) of the *Divorce Act, 1985*, and pursuant to the provisions of subsections 21(6) and 25(3) of the Act.

2. *Grounds and Bars to Divorce*

Subsection 8(1) of the *Divorce Act, 1985* establishes the breakdown of a marriage as the sole criterion for divorce, but subsection 8(2) of the Act imposes limitations on the means of proving a breakdown of the marriage. Pursuant to subsection 8(2) of the *Divorce Act, 1985*, marriage breakdown will be established "only if" the spouses have lived separate and apart for at least one year immediately preceding the divorce judgment, or a spouse against whom a divorce is sought has, since the celebration of the marriage, committed adultery or treated the applicant spouse with physical or mental cruelty of such a kind as to render continued marital cohabitation intolerable.

Paragraph 8(2)(a) of the *Divorce Act, 1985* stands in marked contrast to the provisions of paragraph 4(1)(e) of the *Divorce Act*, R.S.C. 1970, c. D-8. Not only has the separation period been reduced from three or five years to one year, but either or both spouses may now institute proceedings for divorce without awaiting the expiration of the period. This should result in a significant increase in the number of divorces granted on a no-fault basis and, consequently, may reduce the acrimony so frequently associated with fault grounds and the traditional adversarial process.

Section 11 of the *Divorce Act, 1985* replaces section 9 of the *Divorce Act*, R.S.C. 1970, c. D-8 and eliminates the bars formerly established by paragraphs 9(1)(d) and 9(1)(f) of that Act. The bar previously defined in paragraph 9(1)(e) of the *Divorce Act*, R.S.C. 1970, c. D-8 which was designed to protect the economic security of children, has been reformulated and is now applicable to all divorce proceedings. Collusion is retained as an absolute bar to divorce in all cases and condonation and connivance have been retained as provisional bars to divorce where the applicant's proof of marriage breakdown is dependent upon the respondent's adultery or cruelty.

3. *Economic Rights and Obligations*

Pursuant to section 4 of the *Divorce Act, 1985*, an application for spousal or child support or for custody or access may be heard and determined after the granting of the divorce judgment. Any limitations hitherto arising from the words "upon granting a decree *nisi* of divorce" in subsection 11(1) of the *Divorce Act*, R.S.C. 1970, c. D-8 are thereby removed.

For the most part, sections 15 and 17 of the *Divorce Act, 1985* define identical criteria and objectives to govern original applications for corollary financial relief and applications to vary, rescind or suspend subsisting orders.

The decision of the Supreme Court of Canada in *Nash* v. *Nash*, [1975] 2 S.C.R. 507, 2 N.R. 271, 16 R.F.L. 295, 47 D.L.R. (3d) 558, has been abrogated by subsections 15(2), 15(3) and 17(3) of the *Divorce Act, 1985*, whereby the court may now make orders to "secure or pay or to secure and pay" interim or permanent spousal or child support. Subsection 15(3) of the Act also expressly empowers a court to order a lump sum in addition to or in lieu of periodic sums by way of interim spousal or child support.

Specific objectives to be considered by the court in determining the right to and quantum of child support are defined in subsections 15(8) and 17(8) of the *Divorce Act, 1985*. It is doubtful whether these subsections represent any departure from the principles previously enunciated by Kelly, J.A. in *Paras* v. *Paras*, [1971] 1 O.R. 130 at 134-135, 9 R.F.L. 328 at 331-332, 14 D.L.R. (3d) 546 at 550 (Ont. C.A.).

In the context of spousal and child support, subsection 15(5) of the *Divorce Act, 1985* requires the court to have regard to the condition, means, needs and other circumstances of each spouse and of any child of the marriage for whom support is sought. This subsection also specifically requires the court to consider the duration of cohabitation and the functions performed by each spouse during cohabitation. The court must also take account of any order, agreement or arrangement relating to the support of a spouse or child. The factors identified in subsection 15(5) of the *Divorce Act, 1985* as relevant to the determination of the right to and quantum of spousal or child support are to be examined in light of the objectives defined in subsections 15(7), 15(8), 17(7) and 17(8) of the Act. Pursuant to subsections 15(7) and 17(8) of the *Divorce Act, 1985* (the latter subsection relates to variation proceedings), an original order or variation order that provides for the support of a spouse or former spouse should: (i) recognize any economic advantages or disadvantages arising from the marriage or its breakdown; (ii) apportion between the spouses or former spouses any financial consequences arising from child care; (iii) relieve any economic hardship arising from the marriage breakdown; and (iv) in so far as practicable, promote the economic self-sufficiency of each spouse or former spouse within a reasonable period of time. Judicial implementation of these newly defined policy objectives may well result in a shift away from the narrow perspective of a "needs" and "capacity to pay approach" that has pervaded Canadian jurisprudence in the past decade.

Subsection 15(4) of the *Divorce Act, 1985* empowers the court to make a support order for a definite or indefinite period or until the happening of a specified event, such as the remarriage of the payee. Where support has been ordered for a fixed period or until the occurrence of a specified event, subsection 17(10) of the *Divorce Act, 1985* imposes severe limitations on the jurisdiction of a court to vary that order for the purpose of resuming support, if the application to vary is brought after the expiration of the fixed period or the occurrence of the stipulated event.

Pursuant to subsections 15(6) and 17(6) of the *Divorce Act, 1985*, "any misconduct of a spouse in relation to the marriage" is to be ignored in determining the right to and quantum of spousal or child support. Subsections 15(9) and 35(3) of the *Divorce Act, 1985* provide that an order for spousal or child support may be assigned to a designated federal or provincial Minister of the Crown or to any member of the Council of the Yukon Territory or of the

Northwest Territories. These subsections may be of particular importance with respect to present and prospective provincial systems of automatic enforcement that shift the burden of enforcing orders in default from the family dependants themselves to duly appointed enforcement personnel.

4. *Parenting Rights*

Between 1969 and 1978, 48.3 per cent of all dissolved marriages involved no dependent children. The remaining 51.7 per cent involved a total of 504,358 children. Wives received the custody of the children in 85.6 per cent of all cases and in 95.7 per cent of the cases wherein the wife was the divorce petitioner: see *Payne's Divorce and Family Law Digest* (formerly entitled *Payne's Digest on Divorce in Canada*), 1983 tab at 83-1273 to 83-1275. In the vast majority of cases, matters relating to the custody of and access to the children of the marriage were uncontested and the courts would simply leave things as they were at the time of the spousal separation. In view of the fact that husbands, rather than wives, usually withdraw from the matrimonial home after marriage breakdown, without carrying any children under either arm, preservation of the status quo naturally tends to place the wife in a preferred custodial position. The aforementioned statistics, nevertheless, offer strong support for the conclusion that the so-called "doctrine of tender years" has not been confined to children under the age of seven years and that the judiciary is predisposed to a maternal preference even when custody is contested in the divorce proceedings. Whether such a judicial preference can withstand constitutional challenge under section 15 of the *Canadian Charter of Rights and Freedoms* is yet to be determined.

Although non-custodial parents are usually granted an order for reasonable or generous access privileges on the dissolution of marriage, current judicial decisions in Canada assert that access privileges do not confer any authority on the non-custodial parent to directly participate in major decision-making respecting their children's welfare, growth or development. This position appears to remain unchanged in light of the definitions of "custody" and "access" in subsection 2(1) of the *Divorce Act, 1985*. The importance of maximum contact between the children and both parents is, however, expressly acknowledged in subsections 16(10) and 17(9) of the *Divorce Act, 1985*. Furthermore, subsections 16(4) and 17(3) of the Act specifically empower the courts to make an order for joint or shared custody. It remains to be seen whether these subsections, and perhaps section 15 of the *Canadian Charter of Rights and Freedoms*, will counteract the traditional judicial aversion to orders for joint or shared parenting privileges and responsibilities on the dissolution of marriage.

Subsections 16(6) and 17(3) of the *Divorce Act, 1985* confer a broad discretionary jurisdiction on the court to make a custody or access order for a definite or indefinite period and subject to such other terms, conditions or restrictions as the court thinks fit and just. Subsection 16(7) of the Act also specifically empowers the court to order any person who is granted custody of a child of the marriage to give notice of any intended change of residence to any person who has been granted access privileges. In the absence of any specified period to the contrary, such notice shall be given at least 30 days before the intended change of residence. Given such notice, the person with access privileges will have the opportunity to challenge the intended change of residence in court or seek a variation of the custody and access arrangements in order to preserve meaningful contact with the child.

Pursuant to subsection 16(1) and paragraph 17(1)(b) of the *Divorce Act, 1985*, an application for a custody or access order or for the variation of a subsisting order may be brought by either or both spouses or former spouses or by any other person. Third party applications require leave of court under subsections 16(3) and 17(2) of the *Divorce Act, 1985*. Presumably, such leave will only be granted to persons with some real connection or relationship to the child. It can be anticipated that applications for access privileges by grandparents will increase significantly and are likely to be favourably entertained by the courts, if access is consistent with the best interests of the child.

Subsections 16(8) and 17(5) of the *Divorce Act, 1985* provide that the best interests of the child is the only relevant consideration in any judicial disposition respecting the custody of, or access to, a child of the marriage. These subsections substantially reflect prevalent judicial practices under sections 10 and 11 of the *Divorce Act*, R.S.C. 1970, c. D-8.

Pursuant to subsections 16(9) and 17(6) of the *Divorce Act, 1985*, the court, in making or varying an order for custody or access, shall not take into consideration the past conduct of a person unless the conduct is relevant to the ability of that person to act as a parent. These subsections also reflect prevalent judicial practices under the *Divorce Act*, R.S.C. 1970, c. D-8. They are unlikely to reduce the incidence of bitterly contested custody and access litigation, unless lawyers and the courts invoke alternatives to the traditional adversarial process in seeking to resolve parenting disputes. Such alternatives might include the appointment of independent counsel to represent the children, an increased use of mediation processes where the family members consent, and the appointment of non-partisan and expert assessors to submit reports to the courts respecting the needs of the children and the respective abilities of each parent to accommodate those needs.

5. *Process*

Although the Parliament of Canada has exclusive legislative authority over the substantive law of divorce under subsection 91(26) of the *Constitution Act, 1867*, control over the applicable laws of evidence and over matters of practice and procedure are delegated to the provinces by sections 23 and 25 of the *Divorce Act, 1985*.

The definition of "court" in subsection 2(1) of the Act renders it permissible for the Lieutenant Governor in Council of a province to designate a Unified Family Court that is presided over by federally appointed judges as a court of competent jurisdiction for all purposes of the *Divorce Act, 1985*. In addition, the definition of "appellate court" in subsection 2(1) of the Act, coupled with the provisions of subsections 21(6) and 25(3) of the Act, enable the provinces to determine the appropriate court for hearing appeals and the procedures to be applied in that court. The composition of the appellate court might also be varied according to whether the appeal relates to an interim order or a permanent order for corollary relief. The substantive right to appeal is necessarily regulated by section 21 of the *Divorce Act, 1985*. As stated in an Information Paper on Bill C-47, published in May 1985, by the Minister of Justice and Attorney General of Canada (see *infra*, at p. 175):

> The channeling of appeals is not, however, necessarily incidental to federal jurisdiction over divorce. Every jurisdiction has provision for appeals of judgments or orders of its courts. There is no national interest in a uniformity of appeal routes in divorce proceedings. That is why the new *Divorce Act* provides that appeals will be heard by the appellate courts which usually hear such appeals from the Court designated by the provinces to hear divorce cases.

Although section 26 of the *Divorce Act, 1985* reserves a power in the Governor in Council to override provincial rules of practice and procedure by making federal regulations for carrying out the purposes of the Act, a power similar to that exercisable pursuant to subsection 19(2) of the *Divorce Act*, R.S.C. 1970, c. D-8 has been exercised solely for the purpose of establishing a Central Divorce Registry that conducts a computer search to avoid any duplication of proceedings in more than one court of competent jurisdiction. It appears unlikely, therefore, that the powers exercised under section 26 of the *Divorce Act, 1985* will unduly interfere with provincial rules of practice and procedure.

The former requirement of a "trial" before a judge, which was imposed by paragraph 9(1)(a) of the *Divorce Act*, R.S.C. 1970, c. D-8 has now been abandoned. Although section 7 of the *Divorce Act, 1985* provides that the jurisdiction to grant a divorce is exercisable only by a judge of a court of competent jurisdiction under subsection 2(1) of the Act, paragraph 25(2)(b) of the *Divorce Act, 1985* provides an opportunity for the rule-making authorities in the respective provinces to regulate the conduct and disposition of "any proceedings" under the Act without imposing the necessity of an oral hearing. The use of affidavit evidence in uncontested divorce proceedings has already been implemented in the province of Ontario pursuant to rule 70.21 of the *Rules of Civil Procedure*. In several jurisdictions, existing rules of practice and procedure also empower registrars, masters, family law commissioners and provincially appointed judges to examine the evidence, whether written or oral, in contested claims for corollary relief in divorce proceedings and make recommendations in a report to be submitted to a court of competent jurisdiction as defined in subsection 2(1) of the *Divorce Act, 1985*.

The definition of "application" in subsection 2(3) of the *Divorce Act, 1985* further enables the provinces to introduce procedures and processes pursuant to section 25 of the Act that will reduce the adversarial nature of divorce proceedings. The permissibility of a neutral style of cause and of noncontentious pleadings are clearly envisaged by subsection 8(1) of the *Divorce Act, 1985* which allows an application for divorce to be made by both spouses, at least where the no-fault ground under paragraph 8(2)(a) of the Act is relied upon. Similarly, subsections 15(2), 15(3), 16(1), 16(2) and 17(1) of the *Divorce Act, 1985* envisage the possibility of joint applications by the spouses or former spouses with respect to claims for spousal and child support and custody or access privileges. The interests of third parties may also be acknowledged by new provincial rules introduced pursuant to paragraph 25(2)(a) of the *Divorce Act, 1985*, provided that such rules are consistent with subsections 16(3) and 17(2) of the Act. There is ample opportunity, therefore, for the provinces to devise rules of practice and procedure that will eliminate the ritual of the uncontested divorce trial and also facilitate the disposition of contested issues arising in proceedings under the *Divorce Act, 1985*.

Sections 9 and 10 of the *Divorce Act, 1985*, like sections 7 and 8 of the *Divorce Act*, R.S.C. 1970, c. D-8, impose duties on lawyers representing divorce litigants and on the court to examine the prospects of spousal reconciliation. Pursuant to subsections 10(4) and 10(5) of the *Divorce Act, 1985*, which correspond to section 21 of the *Divorce Act*, R.S.C. 1970, c. D-8, confidentiality is extended to statements or communications made during any reconciliation attempts, at least where they are undertaken before a counsellor or other person nominated by the court. Experience under the *Divorce Act*, R.S.C. 1970, c. D-8 suggests that the statutory duty to promote reconciliation imposed on lawyers and the courts is regarded as a *pro forma* requirement. Not surprisingly, the institution of divorce proceedings usually sounds the death knell of the marriage and, in itself, manifests the absence of any real prospect of reconciliation.

Additional duties are now imposed, by subsection 9(2) of the *Divorce Act, 1985*, on the lawyers for the respective spouses to discuss with them the advisability of negotiating matters relating to support and custody and to inform them of known mediation facilities that might assist the spouses in negotiating a settlement of those matters. The responsible discharge of these duties by lawyers bodes well for reducing the acrimony and hostility that so frequently accompanies the "emotional divorce" and may significantly reduce the incidence of bitterly protracted litigation. Although no similar duty is expressly imposed on the courts under the *Divorce Act, 1985*, mediation processes have been invoked by some courts, particularly in custody and access disputes, and may offer an alternative to an order for an independent assessment of the needs of a child and the capacity of each spouse or former spouse to accommodate those needs.

The potential for new processes and less adversarial stances in the resolution of family disputes arising on divorce is, therefore, considerable. Given the will to promote the more constructive resolution of family conflict, provincial laws of evidence and provincial rules of practice and procedure can open the door for innovative processes that protect, rather than defeat, the interests of all members of the broken family.

9 3.10

FAMILY SUPPORT WORKSHEET

When a family is experiencing a divorce, what are some of the ways people can express their concern and show their support?

INDIVIDUALS/FRIENDS	OTHER FAMILIES	THE COMMUNITY

TOPIC	Promoting Positive Lifestyle Practices

STUDENT OBJECTIVES

The student will be able to:

1. identify ideal health practices characteristic of a healthy lifestyle,
2. assess levels of health and well-being,
3. identify community and school resources that promote adolescent health,
4. recognize the importance of practicing preventive health behavior,
5. describe the relationships of health and lifestyle.

SUGGESTED STUDENT ACTIVITIES

. Propose a list of ideal health practices for a teenager.
. Record scores of personal health and well-being on lifestyle wheel.
. Discuss preventive health practices that promote adolescent health.
. Describe the roles of a variety of community and school health supports.
. Formulate a paragraph about the relationship of healthy practices to positive lifestyle.

REQUIRED MATERIALS

. Teaching Aids: Health and Well-Being Inventory; Lifestyle Wheel; Letter to Parents

RESOURCES

1. Manitoba Education. "Teacher Background Information: Lifestyle; Major Dimensions of Health; Well-Being." Social-Emotional Well-Being Teaching Aids (Grade 9). Winnipeg: The Department, 1984.

DESCRIPTION OF LESSON

I. INTRODUCTION

This lesson serves as a review of the unit. The intent is to encourage students to consider the impact health practices have on lifestyle. To achieve optimal well-being, individuals need to develop a lifestyle that includes healthy behavior that promotes physical, social-emotional, spiritual, and intellectual well-being. The immediate benefits of optimal well-being are apparent. Equally important are the long-term benefits.

DESCRIPTION OF LESSON

To work towards a state of well-being, each person needs to recognize and reduce health risks, recognize and change unhealthy patterns of behavior and establish health patterns that promote optimal well-being.

The desire to be healthy needs to come from within the individual. Parents, teachers, and key health professionals can assist in providing knowledge, support, and incentive for the effort to pursue a healthful lifestyle for a lifetime.

II. SUGGESTED STUDENT ACTIVITIES

A. Generate a class list of ideal positive health behaviors of an adolescent. Categorize the health behaviors listed.

Have students complete a worksheet, Health and Well-Being Inventory. Transpose ratings to Lifestyle Wheel and shade in the rating on each section of the wheel. Answer questions at the bottom of the worksheet. It is important to assure students that the worksheet is personal and private. It can be shared with parents.

B. Survey a variety of community and school resources that promote adolescent health. Discuss roles and services and the importance of practicing positive health behavior.

List several health practices teens should know of and practice as young adults. Discuss:

- Breast Self-Examination
- Testicular Examination
- Papanicolaou Test
- Immunization

Pamphlets on these topics are available from Manitoba Health and the Manitoba Cancer Society. Information can also be obtained from a public health nurse, family doctor or health educator.

C. Select a health concern or health practice that might be strengthened. Write a health goal to work towards. Formulate a paragraph outlining the benefits of setting and reaching health goals.

D. Family letters may be sent home to invite students and parents to an evening to discuss and evaluate the program. The teacher should receive feedback about the program of lessons from the students after completion of this lesson.

DESCRIPTION OF LESSON

III. SUMMARY

Encourage students to realize the importance of pursuing optimal health as a lifetime goal.

HEALTH AND WELL-BEING INVENTORY

Read each statement, then decide if it is

never true = 0
true = 1 point
frequently true = 2 points
always true = 3 points

Determine the score for each statement in four categories of health. The maximum score for any category is 30 points. Record points on the Lifestyle Wheel by shading in that amount of the category illustrating your score.

INTELLECTUAL HEALTH

1. I take an interest in current health information.
2. I know and use community health resources appropriately.
3. I have insight into my health status.
4. I consider consequences when making decisions.
5. I apply health information, attitudes and skills in my daily life.
6. I set health goals.
7. I use assertiveness appropriately.
8. I feel increasingly responsible for personal health.
9. I feel motivated to continue learning.
10. I recognize the relationship of health behavior to lifestyle.

SOCIAL-EMOTIONAL WELL-BEING

1. I can give and receive honest compliments and criticism.
2. I encourage others.
3. I act according to universal values.
4. I look forward to my future.
5. I enjoy doing things on my own on occasion.
6. I feel a responsibility to family and community.
7. I feel a sense of personal worth.
8. I communicate positively with family.
9. I communicate positively with friends.
10. I am loyal.

Total Score ____

HEALTH AND SAFETY

1. I follow safety rules.
2. I avoid drugs including cigarettes, caffeine, and alcohol.
3. I avoid potentially dangerous personal situations.
4. I take precautions around strangers.
5. I avoid hitchhiking.
6. I wear a seat belt in motor vehicles.
7. I care for my body and follow positive health practices.
8. I eat nourishing snacks and meals for sufficient energy.
9. I practice responsible sexual behavior.
10. I receive regular medical and dental attention.

Total Score ______

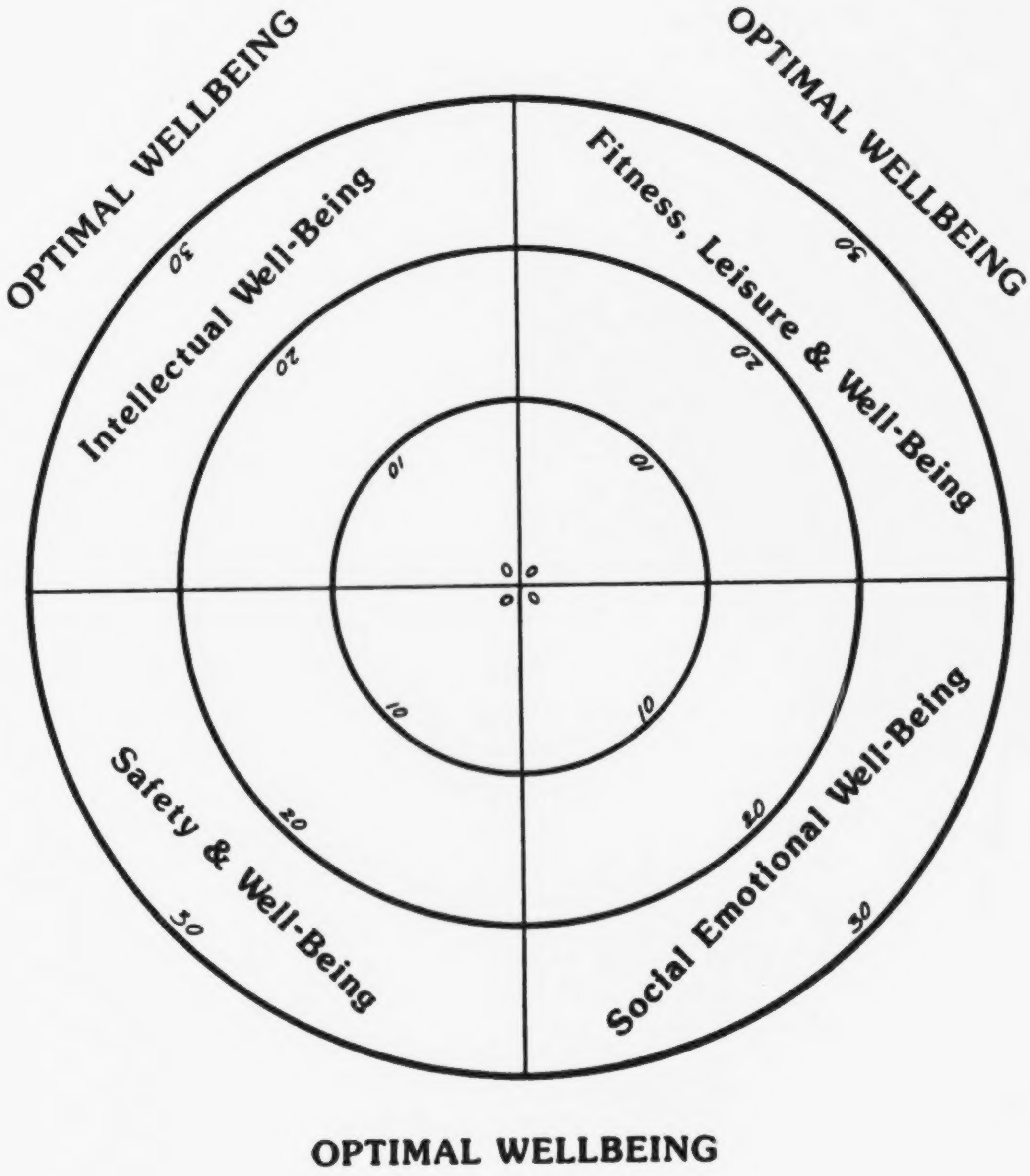
FITNESS AND LEISURE

1. I find time for sufficient rest and sleep.
2. I make physical exercise a regular part of my life.
3. I am involved in a community activity.
4. I have a hobby I enjoy doing.
5. I exercise three times a week for at least twenty minutes.
6. I warm up before and cool down after exercise.
7. I like to be actively involved in sports and leisure activities.
8. I climb stairs rather than use the elevator.
9. I walk rather than ride.
10. I have enough energy to put in a full day.

Total Score ______

9 4.1

LIFESTYLE WHEEL


OPTIMAL WELLBEING
OPTIMAL WELLBEING
Intellectual Well-Being
Fitness, Leisure & Well-Being
Safety & Well-Being
Social Emotional Well-Being
0
0
0
0
10
10
10
10
20
20
20
20
30
30
30
30
OPTIMAL WELLBEING

QUESTIONS

1. Is your health in balance? Why or why not?
2. What improvements might you wish to make?

TEACHER DIRECTIONS:

It is suggested that students encourage their parents to assist them in working on their health project.

Rx for Lifestyle

GOAL STATEMENT

REASONS TO REACH GOAL:

STEPS TO REACH GOAL:

1.

2.

3.

SUPPORTS NEEDED:

PROGRESS NOTES:

Day 1:

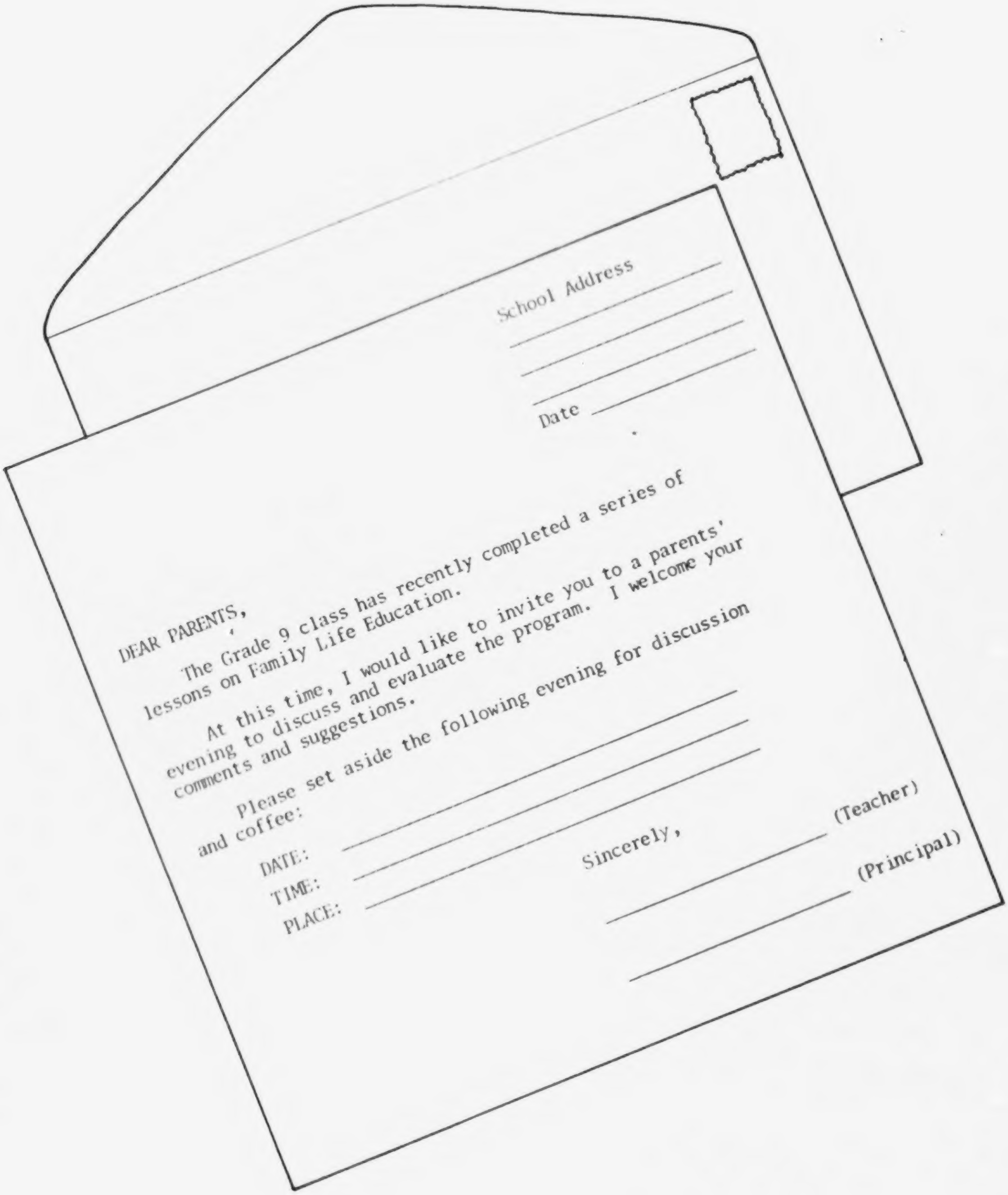
Day 2:

Day 3:

Day 4:

Day 5:

Weekend:



School Address

Date

DEAR PARENTS,

The Grade 9 class has recently completed a series of lessons on Family Life Education.

At this time, I would like to invite you to a parents' evening to discuss and evaluate the program. I welcome your comments and suggestions.

Please set aside the following evening for discussion and coffee:

DATE:

TIME:

PLACE:

Sincerely,

(Teacher)

(Principal)

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FAMILY LIFE EDUCATION AUDIO VISUAL RESOURCES

GRADE NINE

LESSON	TITLE	TOPIC	DISTRIBUTOR	COST
1.0	**THE IMPORTANCE OF FAMILIES**			
1.2	And They Lived Happily Ever After	Family Stages	McIntyre Films	$ 159.50 filmstrip $ 179.50 sound slides
1.3	Peege	Family Aging	International Tele-Film Enterprises	$ 714.00
2.0	**HUMAN GROWTH AND DEVELOPMENT**			
2.1	Then One Year	Endocrine and Puberty	Gordon Watt	$ 555.00 16 mm $ 385.00 video
	or			
	Coping With Adolescence: Understanding Puberty		Wintergreen Communications	$ 95.00 filmstrip
2.2	Then One Year	Puberty and Reproduction	Gordon Watt	$ 555.00 16 mm $ 385.00 video
	or			
	The Facts for Girls		Marlin Films	$ 866.00 16 mm $ 415.00 video
	The Facts for Boys		Marlin Films	$ 866.00 16 mm $ 415.00 video

FAMILY LIFE EDUCATION AUDIO VISUAL RESOURCES

GRADE NINE

LESSON	TITLE	TOPIC	DISTRIBUTOR	COST	
2.4	The Miracles of Life: The Nature of Things Series	Human Reproduction	Marlin Films	$1,475.00 $ 551.00	16 mm video
	or				
	Pregnancy and Birth		Institute Fur Und Bild		
	or				
	Human Reproduction 3		McGraw-Hill	$ 455.00	
3.0	**DILEMMAS AND ISSUES**				
3.2	Everything But	Dating	McIntyre Films	$ 139.00	filmstrip
3.4	Postponing Sexual Involvement (teacher resources)	Abstinence		$ 30.00	kit
3.5	Gentle Art of Saying No	Sexual Involvement	Interntional Tele-Film Enterprises		filmstrip
alternate	Saying No		Magic Lantern Films	$ 540.00	
3.7	Fetal Alcohol Syndrome (optional)	Drugs and Pregnancy (optional)	Visual Education Center	$ 430.90	

LESSON	TITLE	TOPIC	DISTRIBUTOR	COST
3.8	Sexually Transmitted Diseases: Causes, Prevention and Cure	Sexually Transmitted Diseases	Guidance Association	filmstrip
3.9	Beware the Rapist	Sexual Assault Prevention	Canadian Learning	$ 608.00
3.10	Divorce	Family Change	Coronet	$ 715.00